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THE

MEDICAL ANALECTIC

A

WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS
OF MEDICO-CHIRURGICAL PRACTICE

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EDITED BY

R. W. AMIDON, M.D.

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EDITED BY R. W. AMIDON, M.D.

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THERAPEUTICS.

Didier (A.) on Faradization in the Cure and Diagnosis of Hysteria.—As a result of experimentation in twenty-two cases, the author concludes that faradization is one of the best methods of stopping an hysterical attack. In his experience it has never failed to abort an attack in simple convulsive epilepsy, while it is generally successful in hystero-epilepsy. In the latter attacks he considers it more advantageous than ovarian compression, which may injure the pelvic viscera when frequently repeated, and is unadvisable during pregnancy.

Faradization thus therapeutically employed may sometime clear up a doubtful diagnosis, as in epilepsy it will have no effect in shortening the attack. In those confusing cases where the two ailments coexist, the hysterical element will disappear, while the epileptic manifestations will continue.

The application consists in placing at the beginning of an attack the electrodes of a faradic battery along the course of the aura (for example, one electrode on the epigastrium and one on the anterior cervical region when the aura is of the common gastric form), and allow a current of medium intensity to pass. When the tonic or clonic stage has been reached before the application can be made, one electrode should be placed upon the neck and another in the hand, or each in a hand.

Besides its abortive action, the author thinks the treatment curative; applications being made whenever practicable during an attack, and general treatment being given, he asserts that they become less and less frequent, and finally disappear.—*Lyon Médical*, Dec. 2, 1888.

Clarke (J. M.) on β-Naphthol in Enteric Fever.—In β-naphthol we have found a substance very insoluble, and having at the same time sustained and powerful antiseptic properties. Moreover, it is only toxic in large doses—about eight ounces in the twenty-four hours for an adult of average weight—while forty grains distributed over the twenty-four hours are sufficient to keep the intestinal contents aseptic.

But whilst giving naphthol it is also advisable to control the pyrexia that necessarily occurs in the course of typhoid, and so to prevent the damaging effects on the tissues and organs of the body of a long-continued high temperature; we should therefore together with naphthol administer an antipyretic, preferably perhaps antifebrin or phenacetin, whenever the temperature rises beyond a certain height, say 102° F.

The drug is given suspended in milk, and a small quantity of pure milk is taken after the dose. The doses must be administered frequently in order to keep up a constant effect, and small doses have also the advantage of not giving rise to the pungent after-taste in the throat that naphthol is apt to produce. To adults it may be administered in gelatine capsules, or the following formula, which seems the most satisfactory after several trials, may be made use of: ℞ β-naphthol gr. xx., Tr. aurantii ʒ ij, Syr. limonis ʒ ss, Mucila-

ginis tragacanthi ℥ iij, Aq. ad ℥ vj. Dose, ℥ j.

Taste, however, is practically abolished in most cases of enteric fever, and the patients to whom I gave it in milk make no complaint on this score.

Out of seven cases, four, of whom two were boys of twelve, took the drug in doses of 3½ grains every two hours during the whole course of the disease, until the temperature remained normal for five or six days: one boy aged ten took gr. iss instead of gr. iij doses. In two cases the naphthol had to be discontinued before the termination of the fever. In addition antifebrin or phenacetin was administered in the manner stated above.

The patients' ages varied from ten to thirty-two years. Taking first the five cases in which naphthol was given throughout the illness, the average duration of fever, reckoned from the first appearance of spots to defervescence, was thirteen days. Diarrhœa was in all slight, and the stools became at once very much less offensive than before naphthol was given, though still retaining the characteristic appearances and alkaline reaction of typhoid evacuations; there was never more than a moderate degree of abdominal distension, this symptom, when in marked degree on admission, showing diminution in a few days. The tongue cleaned early, and there was not the usual degree of dryness of the lips and mouth, nor of the dirty brown fur so often found on the tongue towards the end of the second week and succeeding the period of fever. Enlargement of the spleen was not detected in four of the cases, and only in slight degree in one. There was certainly less pain and tenderness in the abdomen than is generally found, and no albumen was present in the urine.

As to temperature, it followed the usual course, the highest range being from 103.5°–104.8°F. There was a varying amount of bronchitis. One of the boys complainad in the third week of the disease of pain in the stomach after his milk, so the naphthol was stopped for two days, and was then continued wirhout further trouble.

It might certainly be anticipated that naphthol in checking the abnormal fermentations taking place in the alimentary canal, would also hinder the normal fermentative process of digestion, and give rise to dyspeptic disturbance. Although I believe that this does not occur in the majority of cases, in the two following instances the use of the drug was stopped on this account. The first patient, a girl of twenty-three, was admitted with irregular rises of temperature ranging from 101°–103.4°, but with no spots or other symptoms of enteric fever. The stools, dark, liquid, and offensive, were rendered at once almost odorless by the administration of naphthol. After eight days she improved, and the temperature became normal during the two following days; it then began to rise, and the typical symptoms of an attack of typhoid developed themselves, the spots appearing on the seventh day from the commencement of the rise of temperature; on the fifth day of this period the naphthol, which had been steadily taken from the day of admission, was discontinued on account of its exciting pain and vomiting. The vomit consisted of a large amount of very firm hard curd, barely corroded by the gastric juice, indicating perhaps that the action of pepsin was interfered with.

In the second case a relapse occurred eleven days after defervescence from a mild first attack; the patient had been taking naphthol during the whole twenty-three days occupied by the first attack and subsequent apyrexial period, and appeared to be convalescent, until a severe relapse occurred lasting four weeks and nearly proving fatal. On the sixth day of the relapse there was much pain in the lower part of the abdomen, considerable distention and vomiting: naphthol was therefore stopped, and the pain and distention became less, whilst the vomiting ceased on the following evening. The stools became very much more offensive after the drug was discontinued. In these two cases naphthol certainly seemed to excite gastric disturbance; if it had been discontinued for a day or two, it might perhaps again have been given without further trouble, as in the case of the boy mentioned above; but one did not like to run the risk of exciting a return of the sickness. Both these patients made a good recovery. It was disappointing to see in the first case a typical attack of enteric fever developing, and in the second a relapse occurring, in these patients who had been taking naphthol regularly for some time previously, for on the theory on which its use is

based, relapse especially should be prevented. The aim of the plan of treatment being to put a stop to the growth and further multiplication of the virus in the alimentary canal, and in this way to prevent constant fresh supplies of toxic material—whether actual micro-organisms or the poisonous products of their life-action—passing into the general circulation and maintaining the morbid process, one chief test of the practical value of the method would be the non-occurrence of a recrudescence of the disease. In these two instances, in spite of the administration of naphthol, the bacillus appears to have maintained its injurious activity unimpaired.

One point came out prominently, namely that convalescence was more rapid than usual, and that the patients were less reduced in strength than is generally the case. I should like also to call attention to the absence of albuminuria, of any but the slightest degree of splenic enlargement, and of secondary complications. The disinfection of the stools, as shown by loss or reduction of offensive odor, might also reduce the risk of propagation of the disease to nurses or attendants. The author concludes :

(1) That the production of intestinal antisepsis is a rational mode of treatment of enteric fever, and that β-naphthol is a safe and tolerably efficient agent for this end.

(2) That by its use in the above cases the duration of the disease was shortened, and the intensity of the symptoms directly arising from profound disturbance in the alimentary canal was lessened.

(3) That the tendency to the occurrence of splenic enlargement, albuminuria, and of secondary complications such as boils, abscesses, etc., of purulent infective origin, is diminished.

(4) That complete convalescence is more speedily and satisfactorily attained : and that there is less risk of a propagation of the disease to others.

Finally we must bear in mind that in some patients naphthol may excite so much gastric disturbance as to prevent its use.—*Practitioner*, Dec., 1888.

Park (R.) on Some of the Pyogenic Bacteria and the Germicidal Activity of Certain Antiseptics.—During the past year and a half the writer has, in connection with his former assistant, Dr. Matzinger, carefully investigated the biological character of pus from fifty-two different patients. The method has been similar to that generally adopted, a drop of pus being removed on a sterilized needle at the moment of its evacuation, transferred to gelatine or agar, and then carefully developed through successive generations until its bacteria could be identified. Only one opportunity of examining pus from hypopyon presented itself. This has been of especial interest, because it has been stated by some writers that pus, in which bacteria were present, could not disappear spontaneously. In this particular instance the anterior chamber was tapped, and the pus evacuated was examined with the result given below. The anterior chamber, when filled with pus, was not further disturbed and the pus in time disappeared by apparent absorption.

Simultaneously with these experiments another series was carried on to see the inhibitory power of various antiseptic substances, either recent or old. Jellies were prepared containing the drug experimented with in various proportions. The bacteria experimented with were the pyogenic and some of the other specific forms, as well as one or two of the chromogenic. It was observed that iodoform makes a very poor showing when studied in this way, and this leads me to reiterate a statement frequently made in other connections, that oxide of zinc has all the good properties of iodoform and scarcely any of its disadvantages. In every way in which I have tested it, I have found it to yield, experimentally and clinically, just as good, if not better, results.

Hydronaphthol and boric acid appear to best advantage under these tests. This also bears out personal experience, since the writer has perhaps never been disappointed in the use of either of these drugs ; while for nearly two years he has been using hydronaphthol solutions for every purpose for which he previously used carbolic acid.—*Med. News*, Dec. 1, 1888.

Holladay (W. M.) on Phenacetine, an Antifebrile and Antineuralgic.—The first case in which I used it was that of a neurotic girl, with intense facial, as well as visceral neuralgia. I had given morphia, for relief of pain, both hypodermatically and by mouth, but with only transient relief ; then I ordered phenacetine in six-grain doses, every three hours, with

relief of pain in half an hour, and some narcotic effect. The patient was "very happy" and very loquacious. At the expiration of two hours, the pain returned, but not so severely as before. The dose was then repeated with about the same effect as before. One thing was noted, that the pain was less severe after each dose when it did return, and after the sixth dose there was no more neuralgia.

I next tried a single dose on myself, ten grains for a severe headache; no effect was noted, except the headache was relieved.

I have prescribed it in five cases of headache, with uniform relief—in four cases relief in half hour, but in one not for two hours.

In my second case of neuralgia it was given with the same intoxicant effect as in the first; the young man said he "felt good." This was a case in which I had formerly given antipyrin and morphia, but the effect of the phenacetine was quicker, more pleasant, and lasting than with the other antipyretic. The third case of neuralgia felt no effect beyond the relief of pain; he described the taste "as of moonshine."

I have given phenacetine in one case of "pelvic cellulitis" after delivery, with reduction of temperature, but no relief of pain.—*Va. Med. Monthly*, Dec., 1888.

Flint (A.) on Antifebrin in Sciatica.—The patient was a man of twenty-five, who had a sciatica on the right side of a year's duration. Blisters, iodine, and electricity externally gave no relief. After admission to the hospital external application of flowers of sulphur and stretching the nerve were tried with still no relief. Antifebrin was tried. Fifty grains, in three doses, were given the first day in four hours. The next day forty grains were given, in two doses, in two hours, and the third day complete relief from pain was experienced, and the patient walked about the ward easily. On the fifth day he left the hospital to go to work. On the first day some cyanosis was seen, and whiskey was given with the last dose. —*N. Y. Med. Record*, Dec. 1, 1888.

Dunlap (H. M.) on Oxygen in Pneumonia.—The author says: "I have seen the cyanotic face, with lips almost purple, brighten and assume a more healthy color in a short time under the inhalation of oxygen, and not only is there an improvement in the countenance, but the patient experiences a sense of relief from the distressing dyspnœa which, I believe, could not be afforded by opium or other narcotics, while it is entirely free from the deleterious effects these agents must have in cases of this kind. The patient who has been unable to sleep will drop into a quiet slumber, lasting for a longer or shorter time, as the case may be.

"Every means should be used just as we would do without the use of oxygen.

"In order to obtain good results with this, as with all other remedies, it must be properly applied to suitable cases. Oxygen is not indicated in every case of pneumonia by any means.

"It is in those cases of extensive involvement of the lungs, or where there is lack of oxygenation of the blood as evidence by the cyanotic condition of the patient that this method is especially indicated and in which the best results are obtained.

"However, it is not well to delay the use of this remedy until these symptoms are developed to a very marked degree lest our patient be too far gone to rally and our efforts prove of no avail."

He generally gives inhalations of oxygen and air, equal parts, but when the patient is very weak he gives the gas pure.—*Am. Lancet*, Dec., 1888.

Gibson (G. A.) on Strychnine as an Antidote in Narcotic Poisoning.—In the cases of narcotic poisoning which have come under my own personal notice during the last three years, strychnine has been used hypodermically when there has been any irregularity or interruption of the breathing, which appeared to threaten a failure of the respiratory centre. The effect of the drug is immediately shown by the increased rate, more regular rhythm, and greater depth of the respirations, and even in cases where the breathing has ceased it has again commenced after the administration of the strychnine.

Keeping the patient in the horizontal position, the respiration is to be carefully watched, and if there should be the least sign of irregularity, or shallowness, or inequality in the breathing, one-hundredth or one-fiftieth of a grain, according to the age of the patient, of sulphite of strychnine should be administered subcutaneously, and may be repeated at intervals of an hour two or three times. An immediate improvement in the respiration follows its

administration. If, in spite of the strychnine, the respiration becomes very feeble or ceases entirely, artificial respiration must be commenced promptly, and it should be persisted in until, on the one hand, the respiration is carried on by natural means, or, on the other, the heart has for half an hour ceased to beat. One who reads these remarks should employ strychnine in the manner above described and he will be pleased with its effect.

If the circulation threatens to fail in consequence of the poison affecting the motor mechanism, or of spasm of the arterioles caused by deficient oxygenation of the blood, it also will require prompt attention. The use of the strychnine is of service as a stimulant to the motor centres of the heart, and may be aided by the employment of ammonia or ether; while if artificial respiration has been thoroughly performed there should be no spasm of the arterioles; but in the event of such an occurrence recourse must be had to nitrite of amyl.

In cases of danger from failure of the respiratory centre, caused by the general anæsthetics, the employment of strychnine is likewise of the greatest importance.—*Practitioner*, Dec., 1888.

Herman on the Effect of Glycerine on the Quantity of Secretion Poured into the Vagina.—The author related observations made to see whether the commonly, but not universally, accepted belief, that the local use of glycerine causes a flow of fluid from the vagina, was correct or not. The observations were made with cotton-wool plugs soaked in glycerine, and with pessaries made of gelatine and glycerine. The amount of glycerine inserted into the vagina was weighed, the discharge from the vagina was weighed, and the amount of vaginal discharge from the same patient when glycerine was not used was also ascertained by weight. The result of the observations was in favor of the following conclusions: (1) That when the secretions poured into the vagina are not abundant the local use of glycerine increases them; (2) that when the secretions poured into the vagina are already abundant the local use of glycerine does not increase them.—*Lancet*, Dec. 15, 1888.

Fischer (L.) on Epistaxis: Its Treatment by Oleum Origanum.—My attention having recently been called to the astringent effect of the above remedy, I thereupon used it in the treatment of epistaxis with very gratifying results.

Nor was its effect shown in any specific case, for I took occasion to use it in every case that presented itself, in the same manner as I would have used our other internal remedies.

I have commenced by giving gtt. v., t. i. d., an hour after meals, and increased the dose gradually until in one case I gave gtt. xii., t.i.d.

Owing to the disagreeable smell and taste (oleum origanum being one of the turpentine series) I gave it in the form of an emulsion or in gelatine capsules.—*Med. Record*, Nov. 17, 1888.

SURGERY.

CHOLECYSTOTOMY.

BY GERTRUDE B. KELLY, M.D.,
Assistant Demonstrator of Anatomy at the Women's Medical College of the N. Y. Infirmary.

Doctor Thiriar, of Brussels, at the Third French Congress of Surgery reported[1] the case of a lady, aged 30, from whom, in July, 1887, he extirpated the biliary vesicle. She had suffered for six years from terrible hepatic colics, which nothing could relieve. The vesicle contained no calculi, was enclosed by the liver and duodenum, to which it was firmly adherent. The dissection was a difficult one, as in certain parts the duodenum was deprived of its serous tissue. Finally the vesicle was extirpated. The cure was rapid, and the patient has had no return of the trouble.

Out of six cases of cholecystotomies by Spencer Wells' method there have been three deaths—fifty per cent.,—and one return of the trouble. Out of seventy-two cases of ordinary cholecystotomies—that is, with suture of the biliary vesicles on the abdominal walls—thirteen deaths, or 18.05 per cent.; fifty-nine operated upon have survived. There has been one return, and it had a persistent fistula. We had then fifty-three radical cures, which gave 48.6 per cent. of complete cures.

We know of twenty-two cases of cystectomies, with three deaths after the operation, which makes 13.65 per cent. Of these three failures one is attributed to a cerebral tumor; the second was the per-

[1] *Med. News*, April 28, 1888.

foration of the cystic canal by a calculus; in the third case there were two calculi in the ductus communis choledochus; one was pushed back, the other crushed by Lawson Tait's method.

Cholecystectomy gives us, then, leaving the first case out, a mortality of 9.98 per cent., and all the patients operated upon were cured. In accordance with these results he thinks we must interfere without hesitation. The biliary vesicle is of no use in the economy; it can be extirpated without inconvenience, and if we could demonstrate the existence of a painful cholecystitis, or irritable vesicle, as we have painful cystitis and irritable cystitis, the indication for cholecystectomy could be very much extended; one could resort to it in all painful cases having for their origin an irritable biliary vesicle.

M. Polaillon says[1] that generally the most favorable incision for cholecystotomy is one along the external border of the rectus muscle of the right side. But in order to have more room, one must sometimes add to this a more or less transverse incision a little below the border of the costal cartilage. Opening the gall-bladder may cause hemorrhage, which must be controlled by means of hemostatic forceps, or extravasation of bile, which must be prevented at all hazards by drawing the bladder out and protecting the peritoneum by aseptic sponges. Suture of the abdominal wall completes the operation in cases in which there is no calculus. A biliary fistula is established, and the most pressing danger, intra-peritoneal rupture of the gall-bladder, is averted.

When there are calculi, these must be removed, and the operator must remove all obstructions from the cystic and common ducts, so that bile may escape normally into the intestine. Extraction of the calculi is sometimes a serious difficulty, and Fauconneau-Duferesne recommends diminishing their size by crushing with a small lithotrite. Sometimes it is very difficult to tell during the operation whether all the calculi have been removed, and if all are not removed the operation does not accomplish its end. The mortality of cholecystotomy, excluding the fatal cases not due to the operation, is about 16 per cent. It is, then, a serious operation, but it must be borne in mind that it is performed on patients whose lives are actually in danger. Polaillon advises that the operation always be preceded by an exploratory puncture, so as to confirm the diagnosis.

Courvoisier (Korresp. Bl. für Schweizer Aezrte 1888, No. 3[2]) formulates the following indications:

In case of hydrops or empyema of the gall-bladder, in consequence of occlusion of the cystic duct by a calculus, lithotripsy through the duct wall should first be attempted; this failing, cholecystotomy, with suture and depression of the gall-bladder should be performed. If the cystic obstruction cannot be overcome, an artificial gall-bladder abdominal fistula is indicated; cholecystectomy might even be considered.

In case of complete and persistent occlusion of the common duct, with the consequences of biliary retention, when the obstructing agent is a stone, lithotripsy is to be attempted. If this fail, or if the obstruction depend upon cicatricial growth, an artificial gall-bladder intestinal fistula should be made.

Acute ulcerative perforation of the biliary passages by a calculus demands a laparotomy and search for the perforation. If the perforation is found in the cystic duct, ligature of the peripheral portion and extirpation of the gall-bladder are to be done; if in the common duct, a ligature should be placed on either side of the perforation, and an artificial gall-bladder intestinal fistula made. A similar procedure is indicated in rupture of the biliary passages. Derangement of the biliary excretion by new growths calls for cholecystoenterotomy.

Dr. Zielewicz reports[3] the following case to show how the operation of cholecystotomy may be so modified as to produce the good results of cholecystectomy without, at the same time, incurring the risk dependent upon the performance of the latter operation.

Marie R., æt. 47, mother of several children; poorly nourished and jaundiced in face; complained of severe pains in the region of the liver and the loins. On pressing deeply with the fingers three fingers' breadth below the liver, an elastic tumor, as large as the fist was felt, which was

[1] Quoted in *Med. Jour. and Exam.*, April, 1888. Quoted in *Med. Progress*, Aug. 4, 1888.

[3] Quoted in *Internat. Jour. of Surg. and Antisep.*, July, 1888.

nearly immovable, but apparently not adherent to the peritoneum. The diagnosis of dilated gall-bladder having been made, the contents were drawn off with a Pravatz syringe, and were found to be more purulent than bilious. No bile acids existed in them. On Sept. 22, 1887, laparotomy was performed. An incision was made parallel with the linea alba directly over the tumor and extending beyond. After separation of the peritoneum, a portion of the omentum was forced into the wound, but was found to be loosely attached to the gall-bladder. The tumor was closely adherent to the under surface of the liver; there was no pedicle, and every attempt to separate it was accompanied by severe bleeding, so that the idea of a radical removal had to be given up. A Dechamp needle, with a strong silk thread, was then passed under the cystic duct, which was tied at its central and at its peripheral portion, and the intervening bridge of tissues divided. This incision penetrated deeply into the liver substance and occasioned considerable hemorrhage, which was, however, stopped by compression and iodoform tampons. In this way the gall-bladder was rendered more movable and could be readily drawn into the abdominal wound, to which it was fastened with silk threads. The tumor was now incised and the contents evacuated. They consisted of fluid matter and a gall-stone as large as a walnut, with a rough mulberry surface. The wound was dressed antiseptically, although Bardenheuer affirms that hemorrhage from superficial wounds of the liver are readily controlled, and that large portions of the liver substance may be removed in dogs without much bleeding. Dr. Zielewicz regards cholecystectomy as contra-indicated in cases where there are extensive adhesions, on account of the lengthening of the operation and the consequent danger of collapse. The successful result in his case demonstrates the value of the combined method in some cases, its advantages being: (1) The radical cure of the disease without formation of a biliary fistula and its troublesome consequences, and (2) The simple character of this operation, and the fact that while less dangerous than cholecystectomy, it gives equally good results.

John W. Taylor, F.R.C.S., suggests that when large stones become impacted in the cystic duct, it is better not to use Tait's method of crushing the stones, but to sew the wound in the bladder to the abdominal wall, and syringe the cavity twice daily with warm water. He reports a case in which, after two weeks of such treatment, a stone which it was at first impossible to remove without breaking, and which was so hard that the breaking of it was liable to be followed by serious consequences to the duct wall, became soft and friable and readily removable.

Dr. McLane Tiffany reports[1] a case in which, an exploratory incision having been made, the intestines were found to be adherent to the under surface of the liver and to the gall-bladder. After sewing the parietal peritoneum to the visceral layer of the liver, thus making a "button" of the liver extra-peritoneal, an incision was made through the liver, hemorrhage being controlled by pressure, and the gall-bladder was reached in this way and fifteen calculi removed. The case resulted in recovery.

MEDICINE AND PATHOLOGY.

Newman (E.) on a Nervous Predisposition in the Etiology of Rheumatic Facial Paralysis.—In all of seventeen cases of facial paralysis the author finds striking features which distinctly point to a preponderant action of a nervous predisposition as an etiological factor in the production of facial paralysis, *a frigore*. Among other proofs of his proposition he adduces the following geneological table:

Mme. A., æt. 60.	1st sister of Mme. A., æt. 70.	2d sister of Mme. A., æt. 57.
Neuropathic. Complete left facial paralysis terminating in contracture.	Neuropathic, with intercostal neuralgias and left sciatica.	
	Complete right facial paralysis terminating in recovery.	Complete right facial paralysis; recovery in three months.
Mme. M, daughter of above and own cousin of her husband, M. M.	M. M., son of above and own cousin of his wife.	

have

1st. a daughter of sixteen attacked, in Feb., 1887, with a complete left facial paralysis after an exposure to cold. Recovery at end of month.

2d. A son of thirteen, who is choreic.—

[1] *Amer. Jour. of the Med. Sci.*, June, 1888

L' Union Méd., Nov. 15, 29, and Dec. 1, 1888.

Laugier on Suicide of an Insane Woman with One Hundred and Forty-two Wounds.—Almost every one is familiar with the details of a self-mutilation practised by some lunatics, and the utter disregard of pain shown by some alienated persons is well known, but the case reported by Laugier is almost incredible. The actor in this tragedy was a woman of sixty-three, well known by acquaintances to be very peculiar, and who had had suicidal impulses many times. She was found dead in her room with no signs pointing to murder. There were found on her body, independent of a dozen involuntary wounds in the palm of the right hand, one hundred and forty-two incised wounds.

The woman had attempted to cut the right superficial temporal arteries, the right and left crural arteries, the right and left radial and ulnar arteries; she had sought to reach her heart or lungs by incisions in the chest; she had literally "larded" her abdomen with punctured wounds; she had opened the umbilicus by a vertical incision three inches long, cutting with a sort of drunken fury the loops of intestines as they protruded, and had finished her series of frightful mutilations by three stab wounds of the neck. The instrument she used was a kitchen knife with a blade nine inches long.—*La Therapeutique Contemp.*, Dec. 7, 1888.

Bond (S. C.) on Conditions that Precede Serious Lesions of the Kidneys.—The author, from a study of nearly eight hundred recorded examinations of urine, has come to rely more upon the daily amount of urea excreted than upon any other sign, to diagnose severe structural disease of the kidneys. He divides the cases as they present themselves into three classes:

CLASS 1.—This class of patients pass a diminished quantity of urea, from 6 to 18 grams in twenty-four hours. Generally the urine is diminished, but may be greatly increased in quantity during this period. They complain of being exhausted upon the least exertion, also have dyspnœa, vertigo, nausea, and sometimes vomiting. Always complain of neuralgic pains in various regions of the body, generally more common in the intercostal nerves. They have twitchings of the various muscles of the body and œdema of the hands, face, and extremities which is more or less marked. Patients pass albumen and casts in large quantities, and nearly all, if not quite all of such, are in a condition that will soon bring about that result. This sad ending is reached by a series of explosions which is attributed by the patient to taking cold, but which seems to be the tendency of the disease after it has reached such a degree of destruction to the renal organs and other tissues of the body. This class of patients is such as is described by authors under the head of chronic Bright's disease.

CLASS 2.—This class, as the *first*, pass a diminished quantity of urea in the twenty-four hours with more of a fluctuation in the daily quantity, as shown by several examinations at short intervals, and although this tendency is toward the normal quantity, still very few arrive at this point, and fewer remain long in this condition when the record is still further extended. Patients pass but faint traces of albumen occasionally, with a few granular or epithelial casts, but more often neither albumen nor casts are found. This class of patients have neuralgic pains, vertigo, more or less disturbance of the stomach at times, with exhaustion on slight exertion.

Generally after a long time the *second* class fall into the *first*, as shown by examination of urine and symptoms. A few, however, pass into the *third* group, and after a time even into a condition of apparent health. More of this group consult a physician, than those of the *first* class, for the first time, and something can be done for these patients if the disease is recognized at this point.

CLASS 3.—This class comprises a number of patients who pass at longer or shorter intervals diminished quantities of urea in the twenty-four hours, the variation being from 10 to 20 grams, but this condition does not remain constant for repeated examinations, the tendency being gradually to approach the normal standard when properly managed. Still some of these patients pass from this to the second, and even to the first class, and at last die, and the post-mortem reveals chronic interstitial nephritis. This class also complain of general weakness, pain in arms and chest, vertigo, and general nervous disturbances. They pass no casts or albumen. They have but very slight, if any, œdema in

any part of the body, and there is almost always a relation existing between the symptoms and the amount of urea excreted. So much is this the case that, knowing one you can predict the other, *i. e.*, if the patient excretes more urea the patient feels better, and if, on the other hand, the symptoms are worse, the excretion is less.

The author is convinced that this diminished quantity of urea can be made a factor in diagnosis long before albumen and casts occur in the urine, when the patient is going from one doctor to another, being treated for uterine disease, anæmia, dyspepsia, general debility, and nervous exhaustion.

Attention to diet, saline cathartics, digitalis, and nitro-glycerine constitute the chief factors in the author's treatment.—*Jr. Am. Med. Assn.*, Dec. 22, 1888.

Burford (G. H.) on a Mild Form of Septic Toxæmia Occurring after Enemata.—The absorption into the blood and lymph streams of elements from decomposing masses in the intestine is a common result of habitual constipation. The condition is chronic, and its effects are slowly induced. I wish to call attention to a form of toxæmia, similar in origin, but suddenly induced and characterized by symptoms, at least in pronounced cases, peculiar to septic intoxication of a mild type. Inspissated but decomposing fæcal masses, frequently associated with an arid, scarcely secreting mucous membrane, are innocuous so long as their dryness is maintained. If in such case a quantity of warm bland fluid be suddenly introduced from without into the gut, solution of some of the organic products of the decomposition is effected, osmosis goes on even during the short period of temporary retention, and lymph channels and blood stream are charged with a dilute diffusible septic poison. As from other parts of the alimentary canal, the effect of such general diffusion is exhibited often as a sharp attack of urticaria; but as here the diffusible poison is specially noxious, mild septic symptoms are sometimes superadded.

Case 1.—A girl aged twenty-one, with marked gouty diathesis and intractable constipation, was under treatment for chronic endometritis. Enemata were freely administered, with the usual results, from time to time; but at length, after some days' constipation, an enema was followed by a general erythematous rash, excessibly irritable, diffused over the trunk and extremities. There was also some congestion of the tonsils and fauces, but no rise in temperature was recorded. In the course of the day the rash declined, and after forty-eight hours it had quite subsided. There were no further symptoms of note.

Case 2.—Mrs. C——, aged thirty, also under treatment for endometritis, had various mild aperients ordered for troublesome constipation; these were finally supplemented by an enema. Within a few hours a diffused rash appeared, decidedly urticarial in type, and with considerable irritation. A sore throat, with swollen tonsils, further accompanied the rash. The latter gradually subsided, and in forty-eight hours was gone; but the faucial engorgement lasted some four days.

Case 3.—Mrs. S——, aged thirty-six, convalescing from Emmet's operation, had an enema administered, and this was followed next day by a diffuse and well-marked urticaria, the wheals being very pronounced. No sore-throat accompanied this eruption. In two days the skin was again quite clear, and no trace of the attack was left. Some time afterward a second enema was necessary, and this also was followed by a similar rash, but much less pronounced and less diffused. A third enema, after a further lapse of time, had no sequelæ whatever. No pyrexia was recorded during these attacks.

Case 4.—Mrs. A——, aged thirty-two after dilatation of the cervix, had an enema administered, which was followed in about twelve hours by a diffuse papillary rash, with no obvious wheals, although highly irritable. In about two or three days this rash had quite subsided, and there were no further symptoms to record. The patient declared that she was never subject to rash of any kind.

Case 5.—Miss H——, aged thirty, convalescing after operation for division of the cervix, had an enema given, subsequent to which there appeared a red rash of the urticarial type, chiefly involving the extremities and trunk. No throat symptoms or pyrexia were present. After forty-eight hours the rash had quite disappeared. Another enema, administered some time antecedently, had not produced any such effects.

Case 6.—L. S——, aged fifty-three,

after ablation of a lympho-sarcoma from the abdominal wall, made a slow recovery, during which aperients were perpetually required and enema occasionally given. After the last enema a rash rapidly developed, diffuse, irritable, erythematous, and with distinct symptoms of general malaise. The latter lasted a few days, although there was no pyrexia and no sore-throat. The rash soon disappeared, being quite gone in two days, and did not recur.

CASE 7.—Mrs. G——, aged twenty-nine, convalescing from amputation of the cervix uteri. The administration of an enema in this case was followed in a few hours by a typical urticaria, diagnosed as such before the cause was discovered. This rash was diffused over the trunk and extremities, was excessively irritable, and with wheals minute but obvious. No further symptoms appeared, and the skin affection subsided in the usual time. Subsequent enemata were not followed by similar results.

CASE 8.—Mrs. D——, under treatment for cervical erosion and catarrh, had an enema administered, and a few hours afterward a diffuse erythematous rash appeared, universal and pronounced. Coincident with this was a rise in temperature, and a sore throat sufficiently marked to require special medication. The rash soon declined; the pyrexia and sore-throat abated in three or four days, with no recurrence. The temperature did not rise above 102°.

Three other cases, which were at the time diagnosed as suffering with rash after the administration of enemata, but where the details were imperfectly recorded, I can adduce. Miss A——, suffering with chronic pelvic cellulitis, had a pronounced rash, but no other symptom, after the enema. Mrs. G——, aged twenty-two, convalescent after removal of vaginal cysts, had a similar rash, ephemeral in duration. Mrs. B——, with menorrhagia from fibroid, also showed similar symptoms, confined to the skin eruption. In each of these cases a true post-enemal rash of erythematous type, ephemeral and localized, was noted, but with no further constitutional symptoms.

The foregoing cases constitute an ascending series, in which the symptoms become progressively more pronounced and extensive. Commencing with a simple erythematous rash, localized in distribution and mild in type, the next grade presents a typical urticaria, with minute but obvious wheals, diffused over the trunk and extremities, and lasting about forty-eight hours, with sometimes some concomitant malaise. Finally, the severest form has superadded to these skin symptoms such undoubted signs of mild septic intoxication as subacute pyrexia and a concurrent sore-throat, the latter existing for from three to four days. These sequences presented themselves on the average after from three to four per cent. of the enemas administered. They are particularly liable to ensue if enemata be given within three or four days after the administration of ether, in cases where the intestines have not been thoroughly cleared out beforehand. They may appear indifferently after the use of any ordinary fluid as injection, provided it be used in sufficient quantity. With glycerine enemata, where very small quantities only are used, and which of late have been largely used in the Hospital for Women, no such results have accrued. I have seen cases where these post-enemal appearances have been diagnosed as mild scarlatina or rotheln, and it is with a view of eliminating this from the category of doubtful eruptions that I have cited the foregoing cases as illustrative of a hitherto undescribed condition, as well as to record clinical observations regarding the influence of altered alimentary secretions on intestinal resorption.—*Lancet*, Dec. 15, 1888.

Crawford (J. L.) on a Foreign Body in the Peritoneal Cavity.—A woman of twenty-eight consulted me August 18, 1888. She had been a widow for two years. On July 16th, having passed her regular time for menstruation, she concluded that she was pregnant, and at the suggestion of a friend, in order to bring the matters right, she resorted to the use of a lead-pencil, passing it as she thought into the womb. Hemorrhage came on in a short time afterward, and an hour later when she attempted to remove the pencil she could not find it; but felt confident that it had not come away. She then sent for Dr. McDonald, who examined her carefully, but failed to find the pencil, and as there was no pain nor appearance of injury or laceration, he discredited her story; believing that if she had used a pencil at all, it had come away without her knowing it.

The woman continued to perform her household duties until August 18th, almost

five weeks, without any pain or other symptom of trouble. On that day a very tender spot appeared on her abdomen, at a point three inches below and two inches to the right of the navel. Movement became painful, and in this condition she came to my office, reciting the history given above.

I made a careful examination and was satisfied that I felt the pencil in the abdominal cavity just where the soreness and tenderness had developed. This was late on Saturday evening. As the woman was not able to arrange for operation on Sunday, it was postponed until Monday morning, August 20th.

By this time peritonitis had fully developed, and she had suffered intense pain during Sunday and Sunday night; her abdomen was swollen and tympanitic, and her pulse was one hundred, and wiry.

She was anæsthetized, and, with strict antiseptic precautions in every particular, I made an incision through the belly-wall about eight inches long in the median line, commencing near the navel. The pencil was soon found lying transversely, one end near the navel and the other penetrating the ascending colon. The edges of the wound in the colon were freshened and closed by three fine cat-gut sutures.

The intestines and peritoneum were in a highly congested condition. The abdominal wound was closed first by interrupted cat-gut sutures passed through the parts on each side, then a continuous suture was used and the wound perfectly closed except a very small angle at the lower part; no drainage tube was used; the usual antiseptic dressings were applied.

The patient rallied quickly and well from the operation. The patient was kept well under the influence of morphine for several days. She vomited considerably for two days after the operation. Her temperature at no time exceeded 100°, nor did her pulse go above 90. The wound healed by first intention throughout its whole extent. Three weeks from the day I operated, she came on the train and walked four squares to my office; and at the present time she has fully recovered, and for several weeks has been doing her usual work, washing, ironing, etc.

The room in which the operation was performed was a small, low, dingy place, The next day after the operation the room was flooded during the great rain-storm of August 21st, so that in her fright the patient jumped out of bed and was then carried upstairs by a narrow, crooked stairway; but, notwithstanding all the unfavorable surroundings, she made good and rapid recovery.

The part she penetrated in passing the pencil up must be a matter of conjecture. Neither the womb nor any part of the vagina showed signs of laceration at the time I examined her. The pencil was an ordinary lead-pencil, six and three fourths inches long, with a smooth brass cap on the end, which she says she passed first. The lead and glue were softened. The pencil was removed intact, yet it fell apart when exposed to the air.—*Med. and Surg. Reporter*, Dec. 15, 1888.

Maycock (B. J.) on a Peculiar Substance Found in the Heart and Aorta.—The patient was a woman of eigthy-two, with no history of rheumatism, diphtheria, scarlet-fever, or any severe strain. About two years ago she had an apoplectic attack, which, passing off, left no paralysis, but a great amount of general weakness from which she never recovered. At intervals since that time she has had similar attacks, always leaving her with headache, mostly on the left side, and more or less amnesia. When I saw her after an attack of this kind, about six months ago, she presented the following symptoms: Complete loss of memory of words, but her understanding was not much impaired. Tongue, when projected, inclined toward the left. On the left edge of the tongue near the tip was a small purpuric spot. The heart's action was weak and irregular. Physical examination showed the heart to be in a condition of dilated hypertrophy. Over the mitral area, and carried around into the axilla, but not heard behind, was a short high-pitched bruit, commencing just after the beginning of the first sound and terminating either with the sound, or, usually, a little before. That is to say, it was a post-systolic mitral murmur, through which the normal first sound could be distinctly made out. The second sound over the pulmonary valves was not accentuated. Over the aortic area nothing abnormal was noticeable, except that the sounds were not perfectly clear and well defined. The lungs were somewhat œdematous. On Nov. 5th she had an attack more severe than usual, followed by heart failure and death.

An autopsy was obtained. The heart was much enlarged, weighing fourteen

ounces. The left lung was greatly shrunken, and the bases of both lungs were in a condition of brown induration. The liver was somewhat contracted, dense, and on section presented a "nutmeg" appearance, and contained one or two small infarcts. The kidneys were enlarged, and also contained infarctions, the left one in addition having three small cysts.

On opening the heart the ventricular walls were found to be thin, and the cavity large. On the posterior wall of the ventricular cavity there were no columnæ carneæ, but the surface presented a ragged appearance, with what looked to be broken muscular fibres projecting from it. The mitral valves were perfectly competent. Attached to the infero-posterior portion of the cavity was a thin, tough membranous substance about one half inch in width at its point of attachment, then becoming narrower as it extended upward, floating freely in the cavity, passing in front of the mitral orifice, and reaching to the aortic valves. Here it became very narrow and twisted as it passed through the centre of the aortic orifice, the attenuated neck offering no obstacle to the closure of the valves. Attached to this "neck," immediately above the valves and floating perfectly loose and free in the aorta, was a white, perfectly smooth and shining, fibrous, cylindrical body, about one and a half inch long and one fourth of an inch in diameter. The brain was not examined.

All the symptoms found during life were now easily explained. The apoplectic attacks and the hemorrhagic infarctions were no doubt caused by small clots of blood (emboli) or, possibly, by pieces of the structure itself being washed away. The membranous mass in the left ventricle in the course of the blood-current caused the bruit, but the round smooth portion in the aorta gave no sign.—*Med. Record*, Dec. 15, 1888.

Coats (J.) on Extensive Ulceration and Brittleness of Colon, Following an Overdose of Medicine.—The lesion existed in the ascending and descending colon respectively. In the former there are large flat ulcers, with abrupt edges, which appear as if almost punched out, but only extending through the mucous membrane. In the descending colon they are more numerous and smaller, and they are mostly elongated along the circumference of the gut. They are closely set, frequently leaving a narrow bridge of mucous membrane, so that the appearance presented is that of a series of parallel ridges with the ulcers between. The ulcers not infrequently undermine the mucous membrane so as to form bridges. Ulcers were present in every part of the colon, and it was also very brittle, so much so that in removing the intestine several perforations were made, although great care was exercised. There was also some adhesion to surrounding parts, but the adhesions were not very firm.

The case was that of a woman who was admitted complaining of pain in the abdomen and diarrhœa of three weeks' duration. She lived in the hospital for about six weeks, the pain and diarrhœa continuing in spite of treatment. The evening temperatures were febrile. The illness was referred by patient to an overdose of powders, whose nature could not be ascertained, but which were believed to be purgative. She was to receive one powder at a time, but her husband gave her five at once.—*Glasgow Med. Jour.*, Dec., 1888.

The Alleged Increase of Cancer.—Apart from the purely surgical interest attaching to the Morton Lecture on Cancer and Cancerous Diseases, delivered on the 26th ult. by Sir Spencer Wells before the Royal College of Surgeons, the lecture contained in its opening remarks some important statistical information tending to prove that such diseases are on the increase in this country. Thus, in England, during the twenty-six years 1861–87, the mortality from cancer has risen from 360 per 1,000,000 of the population to 606—an increase which, Sir Spencer Wells truly remarked, is far more than can be attributed to improved registration. In Ireland, although the total mortality does not show so striking an increase, yet when this is corrected by reference to the diminishing population of that country, the proportional increase per 1,000,000 is almost as striking as that for England—viz., from 1864 to 1880 an average annual rate of 676, and from 1881 to 1887 a rate of 873. In Scotland the proportion of deaths from cancer is larger than in Ireland. A like increase in mortality from cancer during the last decade is noted in the United States. It is obvious that improved diagnosis of malignant disease and greater accuracy in making returns do not suffice to explain the rise in these figures.—*Lancet*, Dec. 15, 1888.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON DERMATOLOGY.

BY CONDICT W. CUTLER, M.D.

Blanc (H. W.) on Leprosy in New Orleans.—*Age of cases.*—More than half the cases were between the ages of ten and thirty years. The oldest patient was seventy-five and the youngest ten years of age.

Nativity.—About three fourths of the patients were native-born and the majority of the others were Germans. The majority of the parents were, however, foreign-born.

Color.—Thirty-seven out of the forty-two patients were white, but most of these were naturally of dark complexion.

Sex.—The males were greatly in the majority.

Variety.—One variety or form of the disease rarely occurred alone. Leprosy which was purely tubercular, macular, or anæsthetic was very uncommon.

Duration.—As the disease has no initial lesion as syphilis it was impossible to say how long the trouble had existed before symptoms presented themselves. Some patients have power to resist the progress of the disease to a much greater degree than others, while treatment certainly prolongs the lives of the patients, sometimes many years.

Heredity.—One fourth of the patients had relatives affected with leprosy. Some of the patients had perfectly healthy children after the disease began, but as a rule in females, pregnancy ended in miscarriage.

Diet.—Fish and stale meat seemed in a few cases to be a possible source of the disease.

Intercurrent diseases.—Syphilis and malaria are the two diseases most frequently complicating leprosy.—*New Orleans Med. and Surg. Jour.*, Nov., 1888.

Deeckmann on Leprosy.—The patient was a native of Brazil and four years a leper—a typical case of lepra tuberosa and anæsthetica.

After seven months of the strictest and most energetic treatment the patient was sent home cured. The fundamental principle of the treatment was as follows: The application of the strongest possible preparations of the so-called "reducents," especially pyrogallol, chrysarobin, ichthyol, internally ichthyol, up to three grammes daily; creasote and other at present usual remedies. Painting twice daily of the whole body with a 10–25 per cent. salve of chrysarobin, with the exception of the hands, feet, and face, where a 10–15 per cent. salve of pyrogallol was used. This general treatment was conscientiously practised daily for seven months.

Isolated tubercles suitably isolated were excised. Plasters of the above-named medicaments, were applied, especially the salicylo-creasote plaster, on the face.

Nasal and pharyngeal affections were removed by means of the thermo-cautery.—*Med. Times*, Dec. 1, 1888.

The Contagiousness of Leprosy.—The following is the report of a case of direct inoculation with leprosy.

Office of the Board of Health, Honolulu,
September 25th.

This is to certify that we, the undersigned, have this day carefully examined

one Keanu, a Hawaiian man in confinement at the Oahu Gaol, who was inoculated with leprosy by Dr. Arning on November 5, 1885, and we find his condition to be as follows: Ears tubercular and considerably hypertrophied; forehead the same; face, nose, and chin show flattened tubercular infiltration; mouth clean, no tubercles; face generally presents a leonine aspect. Hands puffed, fingers swollen at proximal phalanges, tapering to distal phalanges; tips of forefinger and thumb of left hand are ulcerated from handling hot tin cups of tea or coffee, indicating anæsthesia. Body: Back thickly mottled with flattened tubercles and the surface uneven to feel, color of the same a yellowish-brown; front of the body, chest, and abdomen presents plaques of tubercular infiltration of larger size than back, separated from each other by wider intervals and of a brighter color, in some cases a ruddy pink, especially over upper part of sternum. Legs: The infiltration thins out as far down as the knees, there being one large bright patch on the inside of the left thigh; legs below knees quite clean and skin smooth and even to touch. Feet, œdematous, have poor circulation; bluish color; soles of feet clean. Seat of inoculation, outer aspect of left forearm, upper third, shows a dark purplish scar about 1½ in. long by ½ in. wide, irregular in shape, keloid in aspect, dense and inelastic. The tests for anæsthesia were not made. Eyes with sclerotitis, muddy, and injected. No signs of palsy about muscles of face, orbiculares palpebrarum, hands, or forearms. It is our decided opinion that this man is a tubercular leper.—N. B. EMERSON, M.D., President of the Board of Health; J. H. KIMBALL, Government Physician, Honolulu.—Ed., *Br. Med. Jour.*, Nov. 24, 1888.

Accidental Vaccination.—Some recently reported cases of accidental vaccination are very interesting. Mr. Eminson reports[1] a case of accidental vaccine inoculation on the vulva. "About two years ago a mother of a family sent for me on account of a mysterious affection which had appeared on her vulva. I found a dozen or more large vesicles on the external genitals (on one side only of the vulva, if I remember aright); the woman was anxious, and could give no hint as to the cause. However, the key of the case was found in the room in the shape of her baby, just recovering from vaccination. Failing this key, I might have been puzzled; for, owing to the character of the tissues, or more probably to the method of inoculation, the vesicles were not single and sharply defined, but flattened, and united together along the whole side of the part."

Mr. Puckle says[2]: "While resident physician in the Royal Hospital for Sick Children, in Edinburgh, I had occasion to vaccinate a child aged two. The little patient was a great plaything in the ward, and especially with one of the nursing staff, who had never been vaccinated. As a result, the nurse in question became inoculated. The vesicle was situated as nearly as possible in the centre of the forehead. From the age of the subject (about 25), and the fact of its being the first time she had been subjected to vaccination, she suffered severely. There was great swelling all over the forehead and a great deal of general *malaise*. There was but one vesicle, and it was almost the circumference of a sixpenny piece."

Mr. Blenkarne, writes[2]: "The father of a vaccinated child (about the twelfth day) 'kissed the place to make it well.' He, unfortunately, had happened to have cut his lip whilst shaving that same morning. Inoculation took place, only it differentiated into erysipelas of the face and head, with a very high degree of fever. Purgatives were first given, and I then prescribed that "sheet-anchor" for erysipelas, tincture of the perchloride of iron, and the man made a good recovery."

Dr. W. Easby relates[2] the following case: "Mrs. M., aged 40, who has never been vaccinated, says she had a mild attack of small-pox when a child, which, the doctor who attended her said, rendered vaccination unnecessary. On October 18th she took her baby, aged four months, to the public vaccinator, and again on the 25th for inspection. There were four good vesicles, from which lymph was taken. On the 28th she noticed a pimple beginning to form on the left cheek, and on the 31st I was asked to see her. I found the left side of the face much swollen and inflamed, and over the left malar bone a large vaccine vesicle a little larger than a sixpence. At this date, November 14th, the crust is separating, and nearly all the swelling has gone. She does not remember touching her child's arm in any way."

[1] *Br. Med. Jour.*, Dec. 1, 1888.

[2] *Br. Med. Jour.*, Nov. 24, 1888.

In a case related by Page[1] an infant was vaccinated (two places on the left arm). The mother remembers one day carrying the infant face downwards over her left shoulder, and its arm coming in contact with her face. She probably had some abrasion of the skin of her left cheek and unconsciously and accidentally vaccinated herself through it from the baby's arm on the above-named occasion.

The vaccination ran through its usual course, the scab falling off, leaving a healthy-looking scar considerably depressed.

Dr. Alex. Morison Newark, New Jersey, writes[2]: "During the past fall several instances have come under my notice where children have accidentally vaccinated one another, generally through sleeping together. In one case a mosquito acted the part of surgeon.

"Some time ago, while surgeon of one of the Atlantic liners, I attended a little girl, aged 3 years, who was suffering from retention of urine, following on very painful micturition. She had been vaccinated fully two weeks before coming on board, and the arm then was still swollen and painful. There was a secondary vesicle at the right side of the nose. No urine had been passed for twenty-four hours, except a slight dribble while asleep. On examination, the orifice of the urethra was found to be closed by the swelling from a vesicle situated immediately posterior to it. Cocaine was applied to cause shrinkage and allow of dilatation, but chloroform had to be given ere any thing could be done. A small catheter was at last passed and retained, cooling lotions being applied till the swelling went down. Here there was a history of threadworms, which led to the scratching. In this case, as in others I have observed, the child was strumous, which may or may not have been a coincidence."

Eichhoff on Contagiousness of Alopecia Areata.—Out of 36 patients with alopecia areata, 10 were customers of the same barber, and all had noticed the appearance of the disease soon after a visit to his shop. Two groups of seven and four patients came from the same neighborhood. After the barber in question had disinfected his utensils no further cases of the disease appeared.

Unna, in a letter from Paris to the *Monatsheft für prakt. Derm.* (No. 13, 1888), relates the following instance of the transference of alopecia areata by contagion, as one of the most striking mentioned by Bésnier. In one regiment there were observed eighty cases of this disease. Investigation showed that the officer whose duty it was to attend to the distribution of the uniforms and accoutrements among the men was affected with the malady. These men were all sent away and their helmets burned. One helmet, however, accidentally escaped destruction, and the soldier to whom this helmet was given was subsequently attacked by the disease.—*Boston Med. and Surg. Jour.*, Nov. 22, 1888.

Taylor (R. W.) on Dermatitis Tuberosa of Iodic Origin.—Of this so-called "Acné Anthracöide Iodopotassique" there are, according to the author, only two reported cases, one of them being doubtful.

According to the author's views, iodic eruptions are most simply divided into two classes—the hemorrhagic and dermal inflammatory. The essential lesion, he thinks, in most cases, is dermatitis, pure, and simple, and all other lesions are inflamed sebaceous follicles, forming abscesses, and pustules are secondary to it. In three well-marked cases of bullous eruption of iodic origin, seen within a year, a careful study of them showed that the essential morbid process was the dermatitis, and that the warty and vegetating appearances, which developed during and after the disappearance of the bullæ, were due to its intensity and persistency.

Co-existing tubercles, tuberculo-pustules, subcutaneous nodules, inflammatory patches of fungating appearance, can only be explained on the ground of dermatitis.

The tendency of the iodic eruptions to present fungating and vegetating appearances has led many observers to incorrectly make new and separate forms of these affections. To one form in particular, consisting in circumscribed patches of dermatitis, with the production of tuberous lesions, he thinks that the name *dermatitis tuberosa* applies perfectly. The essential lesion in this morbid process is dermatitis, and the secondary involvement of the sebaceous glands with their cribriform openings and pus crusts, the development of tumors into sessile and mushroom-like forms, are due to exudation and cell-infil-

[1] *Br. Med. Jour.*, Oct. 27, 1888.
[2] *Br. Med. Jour.*, Dec. 15, 1888.

tration, the natural outcome of the inflammation.

The term used by Dr. Bésnier, *acné anthracöide iodopotassique*, in a case reported by him,[1] seems too fanciful and far, pathologically, from being precise. It is true that the openings in some of the tumors seem like those of anthrax, but here the simile ends in every particular, Anthrax is a subcutaneous connective-tissue affection, while this iodic eruption is purely dermatitis.

Under the title "Circumscribed Phlegmonous Dermatitis," Duhring[2] reports a case of what perhaps may be this form of iodic eruption.

The history of the author's case is as follows:

M. F., American, aged twenty-six years, entered New York Hospital December 23, 1883, Had a chancre three years previously, and had followed treatment from time to time. About one month before entering the hospital he began to suffer with severe pains in the head, undoubtedly syphilitic. He was put on 20 grains of pot. iodide, thrice daily, but afterward the dose was increased to 25 grains and then to 40, 60, and 80 grains, t. i. d. Fifteen hours after the iodide was increased to 40 grains the cutaneous effects of the drug began to manifest themselves, but it was still deemed necessary to increase the dose. In a few days the patient began to improve in his general health, and soon was able to leave the wards for the out-patient department, and the iodide was then greatly reduced in amount. A description of the eruption, irrespective of the chronology of the case, is as follows:

Upon the face and neck are a number of perfectly developed tumors and a number in the process of development. These tumors, which began as localized congestive swellings of the skin, were of a deep red color, round or oval in outline, and varied in size from a three-cent silver piece to a quarter of a dollar. In structure they were both pedunculated and sessile, some of them presenting the shape of a mushroom. Around the tumors was a red areola. The growths themselves were soft, spongy, the larger ones baggy and almost fluctuating. Over the surfaces of most of these lesions were a number of cribriform, trumpet-shaped openings, from which a little pus escaped, upon pressure, and formed crusts. The majority of the tumors reached their development within a week, some of them being nearly an inch in height. During this period of development the cripriform openings and the exudation of pus continued, but afterwards disappeared entirely owing to the abscess cavities becoming collapsed. From this time a thin secretion came from the surface of the tumors, which now presented a uniform warty appearance, comparable to simple venereal vegetations. It seemed probable that these lesions, if left to themselves without treatment might have become fungating or papillomatous. These lesions, after reaching their development, showed a tendency to run a chronic, indolent, aphlegmastic course, but caused no trouble, except from the disfigurement.

The treatment consisted in painting the tumors daily with perchloride of iron. At the end of a month some superficial atrophy and pigmentation of the skin was all that remained of the lesions.—*N. Y. Med. Jour.*, Nov. 3, 1888.

Southam (F. A.) on Lipoma of the Palm of the Hand.—The patient was a collier, aged fifty-five years. Eight years ago a swelling appeared in the palm of the right hand, and gradually increased in size for six years without causing any pain or discomfiture. On examination a soft, almost fluctuating and lolulated, tumor occupied the whole of the palm of the right hand, extending from the annular ligament to the clefts of the fingers. It was triangular in shape; the apex of the triangle hung at the annular ligament. The tumor was undoubtedly a lipomatous one.—*Br. Med. Jour.*, Sept. 22, 1888.

Van Harlingen (Arthur) on a Case of Filaria Nudenesis.—The patient first noticed a small red papule under the skin at the back of the hand, accompanied by pruritus but no pain. It soon assumed an elongate form and began to develop at one end, pushing along under the skin, throwing the epidermis up in a ridge, and showing beneath it like a sinuous red cord. It progressed slowly over the back of the hand between the index and middle fingers and down across the palm, being in all about six inches in length and an eighth of an inch in breadth. The patient was given 36 grains of asafœtida a day, which in a

[1] *Annales de Dermatologie et de Syphiligraphie*, page 171, 1882.

[2] *Medical and Surgical Reporter*, December 13, 1879.

week's time cured the patient, leaving a brown trace to mark the former seat of the disease.—*Med. and Surg. Rep.*, Oct. 6, 1888.

Morrison (R. B.) on Skin Diseases in the Negro.—Negroes are less liable than the whites to skin diseases of a severe type. The skin is coarser in all its elements and less sensitive to poisons, to nervous lesions, or constitutional or general influences. Darker the color of the skin, less severe the type of disease. Five hundred cases of skin disease in the negro have been treated and the following general result noted: Acne was rarely seen; the induration of chancre more marked; in erythema nodosum there was but little pain; acute eczema was less frequent than in the white and more easily cured; favus and furunculosis were rare, but herpes facialis very common; keloid and lymphadenitis were very common, as was seborrhœa capitis; pruritus was a very common affection; tinea was common, but very easily cured; dermatitis venenata was very uncommon, and when present itching seemed to be frequently the only symptom; chancre made its appearance sooner after exposure than in the white—the glands were larger and more prone to suppurate.—*N. Y. Med. Jour.*, Dec. 1, 1888.

Fenn (C. M.) on Potassium Permanganate in Anthrax and Furuncle.—The strength of the solution usually used was gr. x to ʒi of distilled water. With a cotton-tipped probe or hypodermic syringe the solution should be made to reach the *fons et origo mali*. A few drops thus brought in contact with the core of a recent boil will, in a majority of cases, abort it; or, if the furuncle is suppurating, this process may thus be materially abridged by daily applications of this solution. In cases of carbuncle, the focus of the inflammation may be reached by one or more of the cribriform openings and the application made through them, or a few drops of the solution injected into the site of the disease.—*South Cal. Pract.*, May, 1888.

Heitzmann (C.) on Salicylic Acid in Dermatology.—The author has used this drug very extensively in skin diseases for the past three years, and has found for it a large range of usefulness. It is cheap, has no smell, and will not stain the skin, clothing, or hair. It has a peculiar action on the horny layers of the skin, and with the exception of acetic acid no agent is so active in softening and finally destroying hypertrophied epithelial tissue. Salicylic acid is also a very soluble parasiticide, especially for tinea circinata and tonsurans. —*Med. Record*, Sept. 22, 1888.

Szadek on Salicylate of Mercury in Venereal Diseases.—After a number of experiments with this drug, the author comes to the following conclusions: 1. Salicylate of mercury is as efficacious a remedy for syphilis as any other mercurial employed until now; it is most suitable for application in secondary affections; given internally it causes the milder symptoms of syphilis to disappear. When introduced into the organism by deep injections, it quickly removes all symptoms of syphilis. 2. Given by the mouth, or by means of deep injections, it does not produce any injurious effects, and in this regard it differs from other mercurial preparations, and may be employed as the most suitable mercurial in syphilis. 3. Employed externally, it is very useful in various local syphilitic affections, producing resorption of gummata and healing up primary and secondary ulcers. 4. In acute and subacute gonorrhœa it produces no abortive action on the course of the disease; in some cases, however, it acts well, causing a diminution in the discharge.—Quoted in *Med. Record*, Oct. 27, 1888.

THERAPEUTICS.

Greene (W. S.) on the Failure of Antifebrin as an Antipyretic.—The following cases show that antipyrin is sometimes successful in the reduction of febrile temperature where antifebrin fails.

1. *Pneumonia.*—A male, aged 25, was taken suddenly ill, August 14th, with severe chills. He was admitted to the hospital, August 17th, with a temperature of 105.4°; pain in left side, rapid, shallow breathing, pulse 110. The respiration at the lower part of the left lung in the axillary region was bronchial, and posteriorly the breath-sound was almost lost, and there was loss of resonance on percussion. There were no other special symptoms. Eight grains of antifebrin were given, but two hours later the temperature was 106.2°. Fifteen grains of antipyrin were then administered, and his fever two hours later was 101.2°. For four days he had no hy-

perpyrexia. On the fifth at noon the thermometer in his mouth showed 105.2°. The administration of eight grains of antifebrin had no effect, and at four o'clock the temperature was 106°. Twelve grains of antipyrin were then given, and at seven the fever was noted at 100.8°. On one subsequent occasion antifebrin failed to reduce the patient's temperature of 105.4° and antipyrin succeeded. Crisis took place upon the thirteenth day of the pneumonia and the patient made a good recovery.

2. *Typhoid Fever.*—A male, aged 34, was admitted August 14th with a temperature of 104.8°. At 6 P.M., in spite of sponge-baths, it had reached 105.2°, and the small dose of six grains of antifebrin was ordered. Four hours later the fever was unchanged, and twelve grains of antipyrin were given, the thermometer two hours after registering a fall to 100°. On the following morning antifebrin in an eight-grain dose did not affect a temperature of 105.2°, and twelve grains of antipyrin pulled it down to 99.8°.

3. *Typhoid Relapse.*—A male, aged 21, was admitted August 19th with a temperature of 103.2°, which rose on the succeeding evening to 105.4°. Antifebrin was given in the usual dose of eight grains, and two hours later, no change being observed in the fever, twelve grains of antipyrin were exhibited, with the result of a fall in less than two hours to 100°. His fever after this rose on occasions as high as 104°, but was controlled by antifebrin and sponging, when these measures seemed needed.

4. *Typhoid Fever.*—The patient was a female, aged 30. Temperature on admission, 102.4°. The third day after admission, on noting a temperature of 105.2°, antifebrin was administered without effect, and antipyrin was subsequently used with good effect. On the fourth day the evening temperature was again 105.2°, and eight grains of antifebrin were given with no result. Twelve grains of antipyrin afterward reduced the temperature; on a third occasion like doses were used to affect a temperature of 105°, and with like results of failure and success.

In the first case there was some doubt if the falls in temperature were not due to a cumulative effect of the two drugs, but the other cases in which longer intervals were allowed to elapse showed the same results. Antifebrin seems efficacious where the hyperpyrexia is not great, below 104° or thereabouts, while antipyrin is equally successful whether the rise in temperature be large or small. Antifebrin from the same package was in use with good results during the time that the failures noted occurred. The dose ordered, eight grains, is as high as I have felt safe in giving, having seen ten grains produce a serious impression upon the heart in a well-nourished adult.—*University Med. Mag.*, Jan., 1889.

Tayler (J. G.) on Aconitia in Neuralgia.—On the 17th of October, 1887, a woman of 20 years came into my office complaining of severe and long-continued toothache. The history revealed that three years previously she had had a severe attack of pain in her jaws, both upper and lower, which caused her to seek a dentist and have two teeth extracted, with the happy result of relieving the pain entirely. Very soon, however, the pain returned, and she again went to the dentist, this time having several teeth filled, the pain, as before, being removed, only to return shortly as severe as before. Thus she went on, the attacks becoming more frequent until she was seldom free of pain, though at times it was scarcely noticeable, then suddenly becoming more excruciating.

I gave her a little cocaine (4-per-cent. solution) with which to rub her gums, and a small vial containing a dozen pills of aconitia, strength $\frac{1}{100}$ grain, with directions to take one pill three times a day. An hour afterward I was summoned in great haste. I found the patient in a state of extreme agitation, walking the floor, wringing her hands, and occasionally sobbing hysterically. She said she had no pain, and did not know what was the matter, but could not control herself at all. When I told her to lie down and keep quiet, she lay down, but almost immediately sprang up and recommenced her walking, wringing her hands and sobbing, etc. She said she thought the pills too small to do any good, so had taken three of them at once. Fifteen minutes afterwards, while putting on her wraps, for she was intending to spend the night with a friend, she felt the peculiar numbness and tingling in her lips and tongue, but thought nothing of it, as I had told her that she might expect something of that sort. She started to her friend's home, but when about half way there she suddenly experienced giddiness; her feet lost sensibility, so that it seemed to her that a cushion or some soft, thick substance was between her feet and the ground;

her fingers felt the numbness and tingling that greatly increased in her lips and tongue, and, to use her own expression, she "felt that she must fly." She turned and *ran* home, a distance of at least thirty rods, without, she says, losing her breath in the slightest degree, though, when I saw her, her respirations were shallow and labored. She frequently sighed; her pulse extremely feeble, though of the usual rate; her surface cold and clammy; her temperature 97° Fahr. (natural for her 98.2°); pupils moderately dilated; sight slightly impaired. It seemed—indeed was—impossible to keep her quiet. Under the use of whiskey, ammon. carb., and digital., her heart regained its power, her flesh took on a natural feel, and in three hours she was quietly sleeping, with the exception of an occasional slight start or moan. The next day she remained in bed, complaining of much weakness and complete anorexia, but her toothache was gone entirely. I saw her a few days ago, when she assured me that she had not had the slightest discomfort with her teeth since that time, now nearly fourteen months, and did not believe they would ever ache again.

A case of sciatica was quickly relieved by three pills a day, and so far as I know there has as yet been no return of the disease. In another case, that of a strong, robust man, I obtained no relief whatever from as many as twelve pills daily, though it is but fair to state that this was a very obstinate case, yielding very reluctantly to the deep injection of chloroform.

From what experience I have had I am inclined to restrict the use of aconitia to those cases whose cause may be found in well defined peripheral irritation, as the drug seems to act with the greatest quickness and certainty upon the extremities of the nerves.—*Peoria Med. Monthly*, Dec., 1888.

Cimicifuga for Buzzing in the Ears.—The value of actea was forcibly brought to the attention of the writer in the case of an elderly gentleman seen in the course of his hospital experience several years since. The case presented a number of interesting features, but only one or two need be mentioned here. He suffered from dyspnœa, due to aortic stenosis, which had developed in connection with an attack of rheumatism, and a peculiarity of his case was, that when warmed up in a comfortable room unilateral sweating of the face was noticed. This was not observed on other parts of the body, and the appearance of the face was quite sufficient to attract attention from the most casual observer. Buzzing in the ears was one of the symptoms complained of, and for the general condition cimicifuga was ordered—fifteen drops of the tincture three times daily, and with very good results. Other drugs were used later on, but none of them seemed to answer as well as that first used. About four years ago, a stout woman, aged forty, applied to the writer for relief from shortness of breath, especially noticeable when going up-stairs. In this instance buzzing in the ears was one of the symptoms, but there was, in addition, cardiac pain, and an examination revealed the presence of an aortic murmur with stenosis. A history of rheumatism was given, the affection manifesting itself from time to time for the preceding fifteen years. Dyspnœa was so great that in order to be prepared for emergencies, a sofa was placed near the door of the dining-room, leading to the kitchen, the latter being two steps lower than the former. For years this sofa had been in constant use, as the exertion required to get up those two steps caused such distressing symptoms that she fell on the floor, an accident of frequent occurrence. Ten drops of the fluid extract of actea promptly relieved all the most distressing symptoms, but, of course, it could never completely counteract the organic cardiac affection. With attention to diet and exercise, and a continuation of the medicine in decreasing doses, she lived very comfortably for many months, but finally succumbed from prolonged attacks of recurrent rheumatism, which refused to yield to every known method of treatment.

Whether warranted or not, a belief prevails that actea possesses the power to increase the rhythmical uterine contractions, and it has been highly spoken of for the relief of congestions of that organ arising from various causes, and in properly selected cases the writer has found it an invariable remedy. In subinvolution, with a flabby condition of the tissues due to anæmia, and where it would not be advisable to exhibit ergot, small doses of the latter drug in combination with therapeutic doses of actea will sometimes effect wonderful changes in a remarkably short time.

Like all other useful remedies, this one is liable to miscarry; an idiosyncrasy may

exist on the part of the patient, or the odor may be so disagreeable that it cannot be taken, but the greatest difficulty is in securing a reliable preparation, and that matter can only be decided by careful observation of its effects when using a sample for the first time, and with each patient the effect should be carefully studied so that enough shall be taken, and yet not too much.—Editorial in *Med. Register*, Dec. 22, 1888.

Bruen (E. T.) on Spartein.—Several times in the author's experience this drug has induced a sensation of numbness in the lower limbs, and in one case paresis to such an extent that the patient could not move; indeed, the paresis amounted to paralysis. He finds it unlikely to disturb digestion, and while it is not so active as digitalis or caffein, it still deserves a trial as a diuretic. He gives from one fourth to one half a grain three times a day.—*University Med. Mag.*, Jan., 1889.

Stewart (D. D.) on Remarkable Tolerance of Nitro-Glycerin.—The subject of these observations has figured before in this journal[1] as, by a gradual increase of the dose, having ultimately taken for several days the equivalent of thirteen minims of pure nitro-glycerin in twenty-four hours. The author now gives[2] the subsequent history of the case.

On Oct. 22d, when last seen, he had been taking for several days fifty minims of a 10 % solution four times daily, making an equivalent of twenty minims of pure nitro-glycerin in the twenty-four hours, with no more effect than the one minim of a 1 % solution dose when he commenced.

Sphygmographic tracings were taken before and after one of these large doses, showing considerable lowering of the arterial tension. The maximum effect was felt in from three to five minutes after taking the dose. It consisted of very slight flushing of the face and a feeling of moderate tension in the head. No headache occurred. Believing the administration of such increasing doses not unattended with danger, tolerance being so rapidly established, the nitro-glycerin has now been discontinued. He had improved steadily. The urine had been for some time normal in amount, and the albumen had decreased from many grammes to but one per litre. No casts could be found in any of the recent specimens examined.

Poisoning with Sulphonal.—In the *Deutsche Medizinal-Zeitung* for November 26th, Dr. Bornemann, who has charge of an institution for the treatment of neurotic invalids, gives an account of the case of a physician, fifty-three years old, a victim to the morphine habit, to whom sulphonal was given among various other hypnotics. On one occasion sixty grains were given shortly after nine o'clock in the evening, and thirty grains more an hour after midnight. Sleep did not follow promptly, but the patient shortly showed symptoms of muscular incoördination of a decided character. It took six days for the ataxia to subside entirely, and during a portion of that time there was great mental depression. The author infers that the action of sulphonal is not confined to the cerebral cortex, for in this case the ataxia was of central origin, inasmuch as the patient's condition was the same, whether his eyes were open or closed. Certainly the case should serve as a reminder that the use of sulphonal is not wholly free from danger.—*N. Y. Med. Jour.*, Dec. 29, 1888.

Erythrin, a New Alkaloid.—Dr. Fernando Altamirano has communicated to the Academy of Medicine of Mexico some researches he has made upon an alkaloid obtained from the Mexican plant Erythrina coralloides, or colorin, as it is there called. The principle with which he has been experimenting, and which he calls erythrin, is a white, spongy, greasy solid, crystallizing in various forms, melting at a low temperature, a dark-yellow liquid with a disagreeable and characteristic odor being formed. It is soluble in water, ether, and in benzol, still more so in chloroform, and very freely in alcohol. It contains nitrogen. Regarding the properties of erythrin, it may be stated that, generally speaking, they present considerable resemblance to those of curare. It acts on the motor nerves, the vitality of which it arrests. It leaves, however, the brain and medulla, the sympathetic, and both classes of muscles unaffected. The action of the heart is not interfered with, or the peristaltic movements of the intestines. Sensation also is unaffected. When administered hypodermically, it rapidly proves fatal, even in very small doses. It is much less active when administered by the stomach, and when injected into the rectum it appears to have

[1] MEDICAL ANALECTIC, Aug. 30, 1888, p. 417.
[2] *Polyclinic*, December, 1888.

little or no effect. Dr. Altamirano has been able to show that erytherin has great power in counteracting strychnine poisoning. The only attempt which seems to have been made to observe the therapeutic effects of erythrin on the human subject was a case of very severe epilepsy, and was by no means successful, the patient succumbing to the disease. It was, however, proved to Dr. Altamirano's satisfaction that doses of 0.6 gramme can be borne without danger by the human subject.—Quoted from *Pharm. Jour.* in *Lancet*, Dec. 22, 1888.

Rively (M.) on the Direct Application of Copaiba in Gonorrhœa.—Having read some time ago a short article by Dr. I. H. Stearns, of Mansfield, Mass., on the abortive treatment of gonorrhœa, in which he advised the direct application of copaiba balsam, I decided to act upon his suggestion. Hence the first case that presented itself to me was subjected to that treatment. It was a young man who, six days previously, had been exposed to contagion. On the evening before I saw him he had noticed slight burning on urinating, and the next morning the burning had increased, and a thin, yellowish discharge had appeared. On examination, I found the meatus reddened. I smeared a No. 23 steel bougie with balsam of copaiba, and introduced it down as far as the membranous portion of the urethra, and allowed it to remain for six or eight minutes. At noon of the same day he noticed that the scalding, on making water, had diminished, and on the following morning there was no trace of a discharge. The second morning I again introduced the balsam-smeared bougie. A third application was made on the fourth day, although he considered himself cured. Four or five weeks after he called on me about another matter, and assured me that no symptom of gonorrhœa had appeared since.

I have tried the above plan of treatment since in eight cases of gonorrhœa in the first stage, and in all but one obtained like results. The exceptional case was that of a young man who insisted upon drinking large quantities of beer and having intercourse with his mistress on the second night after beginning treatment.

In gleet I have obtained no beneficial results at all. This I attributed to the fact that in the majority of cases a gleet is kept up by a stricture. When the stricture is cured the gleet disappears; all other treatment is but palliative. It seems but natural that copaiba would manifest its curative properties to more advantage when applied directly than when compelled to travel through the system first; for when taken by the stomach, the volatile oil passes off by the lungs, while the copaivic acid is excreted by the kidneys. There is usually a slight burning sensation experienced immediately after the passage of the bougie, but this passes off in a few minutes. Of course the ordinary restrictions in eating and drinking must be observed. —*Med. Register*, Dec. 29, 1888.

The Value of Jaborandi and its Alkaloids in the Treatment of Bright's Disease.—The patient was a man of nineteen, who for several months had suffered from some œdema, dyspnœa, and albuminuria. When seen he was propped up in bed and dropsical from head to foot; his eyelids which were distended with effusion, completely closed the eyes. His face was livid, and the swollen condition of the cellular tissues of the neck made it almost as broad as his shoulders. He coughed incessantly; there was copious intrathoracic effusion, and the subcutaneous tissue all over the chest was "doughy" to the touch. His abdomen was as big as a barrel, and there was extensive œdema of the genitals. His legs and thighs were enormously swollen, and water was exuding from them. He was passing a very small quantity of urine, which was of a dirty color and loaded with albumen. As a last resource, but without expecting much from it, I determined to try the subcutaneous injection of hydrochlorate of pilocarpin, and the next day I gave two injections of a quarter of a grain each, one in the morning and the other late in the afternoon. After each dose I covered the patient thickly with blankets. The first effect was a flushing of the face, the saliva was secreted copiously, and within five minutes he broke out into a profuse perspiration. After the first injection he expressed himself as relieved, and he certainly coughed less. On my visiting him the next day, the lad's appearance was improved; he could see out of his eyes; he had passed a fair night, and the dyspnœa was lessened. I continued two injections daily for three or four days, and after each administration he sweated most profusely. I found he became very faint soon after the injection, and to

counteract this I gave him a good dose of gin-and-water before the next one, and repeated this each time afterwards, when he never complained of faintness. Vomiting also occurred, once or twice severely, which induced me to lower the dose to one fifth of a grain, which I injected daily for nine or ten days. The improvement, which commenced early was well maintained. At the end of a week he could sit up in bed, the cough was much less, the thoracic effusion had completely subsided, and his arms and neck were becoming less œdematous. The patient longed for my visits, and always expressed himself as feeling better after a "jolly good sweat." At the end of a fortnight his upper parts were free from effusion, but the abdomen was still much distended, and I hardly believed that we could get rid of an accumulation which at one time threatened to rupture the skin, and which it seemed that nothing but tapping could relieve. I then administered one fifth of a grain on alternate days, and kept this up for another fortnight. He was then passing his usual quantity of urine, the albumen much diminished in quantity; he sat up daily by the fire, and there remained but a little swelling of the abdomen and legs. I continued the injection till the remaining dropsy had subsided. The improvement was maintained, and under a diet of plenty of milk and the administration of iron and convallaria majalis, he was able to go out of doors and enjoy life with comfort.—*Lancet*, Dec. 22, 1888.

PATHOLOGY.

Phelps (G. B.) on Tetanus Hydrophobicus.—A boy, aged sixteen, on November 16, 1886, applied for treatment at the out-patient department of Chambers Street Hospital for a wound inflicted over the left eyebrow by a stone thrown at him by another boy. The bone was exposed, but there was no fracture. The wound was irrigated with a solution of carbolic acid and a dressing applied. Two days later Dr. Phelps saw the patient, when the wound was painful to pressure, swollen, the edges adherent. A cold-water compress was applied, to be kept wet. Eight days after the injury the reddened and swollen condition had disappeared, and a perfectly healthy appearance was present, but the patient had left facial paralysis, and had complained of difficulty in opening the mouth since the day before. The paralysis was on the same side as the wound. The patient was sent to Dr. Amidon, who made a careful examination. On the ninth day the paralysis was more marked, and there was still painful spasm of the left masseter muscle. On the eleventh day he was up and about at his home. There was occasional spasm of the temporal and masseter muscles; he could swallow well, but attempts at examination of the palate caused marked spasm of the muscles of the jaw. Bromides were administered. On the twelfth day the jaws were firmly set, the patient could hardly speak, the face was drawn to the right; he was restless, pulse and temperature normal, respiration 36. He was given liquid food. Bromide of potassium, 360 grains, was administered in twenty-four hours, also 160 grains of chloral hydrate. On the fifteenth day, the patient, having in the meantime grown weaker, was unable to take any thing by the mouth. Any attempt to swallow caused violent spasm of the muscles of deglutition. He died later in the day. The autopsy showed œdema of the lungs.

The case seemed to be a typical one of head tetanus, or tetanus hydrophobicus; it was typical because the paralysis and the trismus were on the same side as the lesion, and the muscles of deglutition were involved.

Of this disease, which was first described in 1870, he had collected 25 cases—20 males and 5 females; the ages varied from 2½ to 59 years. In 22 the paralysis was on the same side as the injury; in 2 on the opposite side; in 1, the injury being on the root of the nose, there was paralysis on both sides; in 10 cases trismus and paralysis developed at the same time, on the average the eighth day after the receipt of the wound; in 11 cases the trismus developed first; in 1 case the trismus developed within twenty-four hours; in 1 not until the fourteenth day after the wound. The percentage of deaths was 68. The average duration of the symptoms was 38 days. Large doses of chloral hydrate seemed to do most good. In 12 cases an autopsy was held, and in some a microscopical examination of the seventh nerve was made, but no cause for the paralysis was found. The wound was the result of an operation in but one case. It had been

suggested that the infectious matter came from the horse. This could have been possible from the manner of infliction of the wound in a number of these cases. In 5 cases the symptoms developed after the wound had fully healed; in some before any reparative process had set in. Various theories had been offered in explanation. The cases were very rare—*Med. Record*, Dec. 1, 1888.

Dickinson (W. H.) on the Differences between Children and Adults in Regard to Morbid Action and the Effects of Treatment.—Children differ from grown people in their greater susceptibility both to exhaustive and recuperatve influences. Such of their diseases as are of the nature of growths partake of the rate of progress which belongs to the period of development. This applies to the fibroses as well as to isolated tumors, though the fibroses are far more infrequent than afterwards. Many inflammatory disorders, particularly of the brain, are more common in childhood than later, but with regard to many inflammations the power of recovery is greater. Those of the lungs are more frequent and cause more deaths, but in the individual the prospect is better. Acute rheumatism is comparatively infrequent, but when it occurs it brings greater danger to the heart. Some febrile complaints are more frequent and some less so than afterwards, but as a rule their proportionate mortality is less. There are special differences in the action of drugs, the most important of which is the greater influence of alcohol for good and evil. Finally, children respond to treatment, as they often succumb to disease, more readily than do older patients, so that with them our responsibility is the greater.—*Lancet*, Nov. 3, 1888.

Oliver on a Cause of Speedy Death in Heart Disease.—In a paper on this subject, the author drew attention to gastro-enteritis as a not infrequent cause of the rapidly fatal termination of cardiac disease. He gave a brief record of three cases out of seven or eight which had come under his notice within the last few years. The patients were all upwards of thirty years of age, were all men, and in none of them, either from the previous history or during the course of the illness, could any thing be found likely to lead one to suspect that death would be induced by the setting up of a rapidly fatal form of gastro-enteritis. In all the symptoms were of an acute character; they frequently developed very quickly, and death, preceded by collapse, occurred either in a few hours or within a few days. The first symptoms complained of were pains over the region of the stomach, and vomiting. Although aortic and mitral regurgitation were the forms of cardiac disease present in all his cases, Dr. Oliver was not inclined to exempt other forms of heart disease from the tendency to end thus. Convallaria had been the drug taken during life by most of the patients; but as death from gastritis had occurred in some of his cases in which digitalis alone had been taken, while in others no cardiac tonic at all had been prescribed or taken, it was clear that convallaria, even in those cases where death had ensued, was not altogether to blame for the gastritis. The writer thought that heart disease and gastro-enteritis stood in some obscure causal relationship to each other.—*Br. Med. Jour.*, Dec. 22, 1888.

SURGERY.

Chisolm (J. J.) on Transplantation of the Cornea.—The author reports the progress in seeing made by the patient into whose opaque cornea he had transplanted a disc of clear cornea from a living rabbit. Six months had now elapsed since the operation. The circular transparent corneal graft, cut out of the rabbit's eye by the trephine, fitted accurately into the hole which the trephine had made for it in the human cornea. It adhered at once, and from that time has become a portion of the man's eye. To ensure union with the contiguous portions of the eye it had to receive blood-vessels and become infiltrated with inflammatory deposits. This was expected of it. It could not have remained transparent and lived. Five blood-vessels can now be traced running into it from all directions, and yet the graft has not become pannitic, as in the human cornea. Through its grayish substance the dark color of iris and pupil behind it can be detected. The patient can now move about without help when before he did not move a step without the aid of a helping hand. He sees large objects ten feet off, and is improving in vision every month. He now walks unattended about the country roads in the

vicinity of his home. His facial expression has undergone a complete change, from one of anxiety and doubt to one of confidence and cheerfulness. The piece of transplanted cornea is in the stage of interstitial keratitis, and is slowly clearing up as does this pathological condition. The patient is watched from month to month, and an improvement is always noted on his return. Objects not seen at a previous visit can be detected. The slow improvement is quite as rapid as is found in some cases of interstitial keratitis in which months and even years are required to give useful sight to blind people; and that in children in which the recuperative processes are much more active than in adults. It may take twelve months yet before all the benefits of the operation can be secured. In the meantime he has already acquired an amount of useful sight quite enviable when compared to his blindness before the transplanting. He is quite satisfied with the improvement in vision as it is, even should he obtain no more sight, and yet there is every evidence of steady, even if it be slow, progress toward better seeing. The amount of comfort which this patient already derives, makes the operation of transplanting a piece of clear animal cornea into the opaque member of the human eye a legitimate surgical operation, full of promises to thousands of active young persons who, up to the present time, have been considered permanently blind beyond the resources of surgical skill. So precious is the blessing of seeing that, when it has been lost, any means towards restoration, even in part, of this doubly valued sense is worth the trying. Skin grafting with a piece of cornea, in suitable selected cases, promises the much-longed-for relief.—*Maryland Med. Jour.*, Dec. 29, 1888.

Charlesworth (F.). Bullet Wounds of Both Lungs; Recovery.—The patient, when about to board a dhow on the night of September 29th, allowed his revolver to fall against the side of the boat, and one barrel went off and shot him in the left breast. The revolver was a naval regulation. The bullet entered one inch above and an inch and a half external to the nipple, and traversed the lung, its wound of exit being three inches to the left of the spine and one inch above the angle of the scapula. He then picked up the revolver, and whilst examining it another barrel went off and wounded him in the right chest. This bullet also traversed the lung, entering an inch above and an inch internal to the right nipple, the wound of exit being in the upper border of the trapezius, midway between the point of the shoulder and the middle line. He was brought to Zanzibar and sent to the French Hospital on the morning of Oct. 1st. On that day hæmoptysis commenced, and continued freely during the night and next day, then gradually decreased, and stopped at the end of forty-eight hours. From that time he never had a bad symptom of any kind, and was discharged nineteen days afterwards, with both exit wounds healed and those of entrance reduced to a superficial character.—*Lancet*, Dec. 15, 1888.

Patton (F. H.) on Aspiration of Cephalhæmatoma.—My son R., aged fifteen, fell on his head from a 56-inch bicycle, August 7, 1888. I saw him almost immediately. He was entirely unconscious from shock, and remained so for an hour or more. There was immediately after the fall a hard swelling with contusion of scalp over the coronal suture on the right side and a blood tumor with clearly defined edges over the left parietal bone, but no contusion of the scalp here. The boy made about the ordinary favorable recovery from severe concussion, but was in a state of hebetude, with headache and some vomiting, for several days.

The point of interest in the case was the very rare cephalhæmatoma. In this case the blood was probably beneath the pericranium, as the tumor was circumscribed from the first and bounded by the sutures of the parietal bone. At the expiration of twelve days the tumor, in my son's case, was aspirated, and ten fluid drachms of blood were removed. A firm compress was applied over the seat of the tumor for seventy-two hours, when all the remaining fluid had been absorbed, and there was no further trouble with the tumor. In a similar case, I should aspirate sooner. Under proper precautions there is scarcely any danger of carrying septic matter or air into a tumor of this character, and I certainly should prefer this chance to anxiously awaiting the result of the slow process of absorption, with the constant dread of suppuration or the formation of a cyst.—*Med. and Surg. Reporter*, Dec. 22, 1888.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

With the active collaboration of

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LEADING ARTICLE.

Concerning Cæsarean Section.—One of the most interesting chapters in obstetrics at present is that which deals with Cæsarean section. The *Medical News*, in a recent editorial review of the subject, styles it "A Cæsarean Revolution in Progress in the United States." This "revolution" emanates from the German, and one writer, speaking of it, deplores the lack of interest and apparent apathy of the British, and takes a pride in the American readiness to press forward in this direction. The very recent literature on the subject turns it toward the light in every direction; first, in the statistical; second, in its relation to craniotomy; third, its relation to pelvimetry; fourth, observation and presentation of cases; fifth, discussion of various steps in the operation.

The *Medical News*,[1] in view of the discussion of this subject, which was to take place at the meeting of the American Gynecological Society this fall in Washington, gives the latest statistics. A list of 131 cases for the past year is brought forward—the collective work of 73 men in Germany, America, Austria, Italy, Russia, Switzerland, Holland, France, England, India, and Denmark. Leopold, of Dresden, has had 14 cases with only 2 deaths; Professor Schanta, of Prague, formerly of Innsbruck, has operated six times without a death. Of the 131 cases of last year, Leopold had three operations without a death, and Zweifel five operations with one death, and in a record of 44 cases under 34 operators there were only 9 deaths. There were 95 saved out of the 131. It is a mistake we think to try to present the idea of the success of the operation in the form of a percentage, as the value of the percentage depends upon the number of cases. One fatal case in a very few will give a very unfavorable percentage of mortality. It would be a gain certainly if the number operated upon should be always given with the number of deaths and recoveries.

The Sänger operation shows a great advance over that of Porro. Its success has also had a tendency to increase the number of cases operated upon. Since January 1, 1887, there have been 16 Cæsarean operations in the United States. Of the favorable cases 4 recovered and 1 died; of the unfavorable cases 4 recovered and 5 died; of the hopeless cases both died. Twelve of the sixteen children were saved and seven mothers. This is an improvement, the writer states, for the statistics of the United States, for there was a time when every Cæsarean case in the hospitals of the United States died.

The tendency of all this discussion in regard to Cæsarean section is to advocate its wider use, a resort to it in early stages, and its adoption in many cases where craniotomy would formerly have been the choice. The ethics of the sacrificing the life of the child to save that of the mother comes under consideration, and the relative

[1] Aug. 25, 1888.

value of each. In one case[1] the Catholic priest aided the woman in her decision. He remarked that "the pregnant woman was the aggressor, that she had made the contract of maternity; the child was passive and had made no contract. In strict equity, entirely apart from ecclesiastical considerations, the child's claims to life should be considered at least equally with those of the mother." However, the writer of the paper takes the usual view of the case, which is that the life of the adult woman who has already contracted relations with society is of incomparably greater value, as judged by human standards, than the problematical existence of an unborn babe, who will come into the world inheriting a poor constitution and surrounded generally with unfavorable influences.

In the treatment of pelvic deformities we have at our disposal five different distinct methods of delivery—the induction of premature delivery, the forceps craniotomy, and Cæsarean section, or some of its modifications. In this discussion of Cæsarean section, early provoked, labor has its advocates, especially among the French, with whom abortion is openly advised when the continuation of labor is likely to prove fatal to the mother. Professor Pajot says: "Those who wait until the woman with a narrow pelvis is at full term, in order then to perform a Cæsarean operation or some other one, are like the savages who cut down a beautiful tree to get at the fruit."

In a paper[2] entitled "Is Craniotomy Justifiable," by Dr. T. Readman, he asks: "May we not hope that the present generation may see the perforator laid aside and more rational and scientific operations substituted for this barbarous proceeding? Does it not seem monstrous that, when we have a thoroughly scientific and tolerably safe alternative, the taking away in the most brutal manner the life of an innocent child should still be preferred? Is such conduct consistent with the great fundamental law of Christian ethics?" Dr. Meadows[3] advocates the total abolition of craniotomy as unscientific, unwarrantable, and abominable. Dr. Barnes thought it hardly advisable to lay down any such hard and fast rules, but in a subsequent paper he remarks:

"The legitimate aspiration and tendency of science is to eliminate craniotomy on the living and viable child from obstetric practice"; yet he further says: "In minor degrees of contraction, say from three inches to three and a half or three and three quarters inches, the opportunities of inducing labor having gone by, the far greater safety to them other obtained by craniotomy, and the prospect of living children in future labors, make craniotomy the proper course to adopt." Besides these men quoted, Tait, Sänger, Harris, Tyler-Smith, Kinkead, Credé, and many others, express themselves against the use of craniotomy.

It will be seen that the most important question with reference to this whole subject is that which refers to the extent of the deformity of the pelvis. Those who have taken a vital interest in this matter have recognized it as such, and laid stress on the necessity for an improved pelvimetry. Dr. Jaggard, in the paper already referred to, justly remarks: "The exact determination and size of the pelvis constitutes one of the most difficult problems in obstetrics." He refers his readers to Dr. Felix Skritsch's monograph, "Die Beckenmessung an der lebenden Frau."

Before passing on to a consideration of the cases which have been presented from time to time during the past months, it is well to refer to the comparison between craniotomy, induced labor, and Cæsarean section, which has been made by Wyder[4] at Berlin, who has as a basis for his conclusions 9,000 cases of labor at the Charité and 6,000 at the policlinic service, material ample enough and favorably situated. He compares the results obtained in Berlin with those of other cities, finding substantially the same agreement. In regard to craniotomy on the living child, he thinks Credé's statement that it should be superseded by Cæsarean section as premature, although he admits that, under favorable circumstances, this is to be expected not far in the future. He quotes the statistics of the policlinics at Berlin and Leipzig, and the Halle clinic, aggregating 215 craniotomies, with a mortality of 5.6 per cent.; the Berlin clinic had a mortality of 13.2 per cent.

Regarding the mortality in different

[1] Case of Conservative Cæsarean Section, Terminating in Recovery, by D. W. Jaggard, M.D.—*Med. News*, April 14, 1888.

[2] *Provincial Med. Jour.*, March 1, 1888.

[3] Transactions of British Gynecol. Soc., 1886.

[4] *Archiv für Gynäkologie*, Band xxxii., Heft 1. Quoted by Dr. E. P. Davis in *Am. Jour. Med. Sci.*, May, 1888.

grades of contracted pelves, he states that in pelves whose true conjugate was three and a half inches and more, the mortality was 15 per cent.; with a conjugate between two and three quarters inches and three and a half inches, mortality ten per cent.; true conjugate between two and one eighth inches and two and three quarters inches, mortality nil. It is in the last class of cases that the Cæsarean section is generally performed. The complications following craniotomy were most frequently caused by efforts at delivery with forceps before craniotomy was done.

Regarding the induction of labor, 306 cases are cited, mortality 3.9 per cent.; and here, also, the cases in which the pelvic contracture was of the highest degree were without mortality.

In comparing these results with those of Sänger's operation, the first fifty cases reported by Sänger are taken; these statistics are criticised, and thought to be collated with an optimistic view of Cæsarean section. Wyder's comparison shows that in contracted pelves the mortality from Sänger's operation is 2.13 times greater than that in craniotomy, and 3.37 times greater than the mortality of induced labor. For "relative indications" (not highly contracted pelves) the mortality of Cæsarean section was 7.1 times greater than that of induced labor in highly contracted pelves. Sepsis is the great danger in Cæsarean section, and when it occurs it is to be ascribed to the operation, for the performance of the operation gives the best possible opportunity for septic infection.

In summing up his conclusions, Wyder recognizes the fact that many cases of labor fall into midwives' hands, or those of practitioners not versed in pelvimetry; they are not, therefore, treated in the most favorable period for Cæsarean section. He considers this operation, like ovariotomy and the removal of uterine myomata, a procedure to be undertaken only in well-equipped hospitals, by skilful operators. In estimating the prognosis of any case of contracted pelvis, the size, hardness, possibility of moulding, and position of the head, and all the other conditions essential for spontaneous birth, cannot be estimated as early as the time urged for Cæsarean section; the prognosis depends not only upon the degree of pelvic contraction, but upon those factors also.

Regarding the child's life, we are to guard it so long as the mother is in no danger, but when she is imperilled her interests only should be considered. In applying Credé's "golden rule" for obstetricians, "What would you do if the patient were your wife, your sister, or a near relative?" Wyder believes that few practitioners would not hesitate to perform Cæsarean section when other methods are available.

In forming rules for practice, Cæsarean section is undoubtedly indicated in highly contracted pelves when the patient is found in advanced pregnancy. In the early months of pregnancy the induction of labor is indicated; with antiseptic precautions it is without danger. In contracted pelves of conjugatæ veræ, two and one eighth inches to two and three quarters inches, Cæsarean section and craniotomy are direct rivals; the maternal mortality of the fifty cases of Sänger's operation, Wyder estimates at 17.9 per cent.; and he believes that when this mortality shall be reduced to that of craniotomy, in hospitals and localities where Cæsarean section can be readily performed, craniotomy should yield to the Cæsarean section of Sänger. He believes that Cæsarean section will be rarely done in pelves but slightly contracted and most rarely in primiparæ.

To present the cases practically to the readers of the ANALECTIC, will be to discuss step by step the operation and the different methods.

All are agreed that the earlier the procedure is determined upon after labor has once begun, the better the chances of success. Exhaustion of the mother by her own fruitless efforts, and injury to the soft parts by the attempts at delivery by means of forceps or version, or possibly craniotomy, tell greatly against the patient. Labor should have commenced, otherwise the uterus might not contract properly, after the extraction of the child.

It is generally agreed that the *abdominal section* should be as short as possible, in the median line. All the antiseptics and precautions incident upon an ordinary laparotomy are used, and the incision is much the same.

The next step in the operation is subject to variation. Sänger recommends making the *uterine incision* in situ and in the median line midway between the fundus and the lower segment. Garrigues[1] turns out

[1] Garrigues: Improved Cæsarean Section with the Report of a Successful Case.—*Am. Jour. of Med. Sci.*, May, 1888.

the uterus, before opening it, and surrounds the cervix with the soft-rubber tubing to control hemorrhage, entrusting the ends to the care of an assistant rather than tying or clamping them, as advised by others. To prevent hemorrhage after the constriction is removed, it should be loosened up very gradually. To put in sutures in the upper part of the abdominal wound before turning out the uterus is considered an excellent thing.

Sänger eventrates the uterus at the time of the extraction of the child, while other operators do not eventrate the uterus at all, but endeavor to avoid the escape of the liquor amnii and the blood from the uterine wound into the abdominal cavity by pressing the sides of the abdominal wound down below the uterine and keeping them as close to the uterus as possible. It should be mentioned that Garrigues calls the attention to the danger of making the uterine incision too low, causing more hemorrhage thereby.

The next procedure is the birth of the child. Sänger recommends the seizure of the feet and extracting the child by that method. Garrigues thinks it is best that the head should be brought forth first. The recent operators seem to have availed themselves of whatever part presented first, one assisting the child forth by the arm and the shoulder, another by the breech. Garrigues' reason for bringing out the head first seem most logical. "The body follows without difficulty, whereas when the extraction is made by the feet it sometimes happens that the uterus contracts around the child's neck, exposing it to the great danger of suffocation and necessitating a dilatation of the wound of the uterus."

If the placenta is near the line of incision, it is cut through at the same time as the uterine wall. After the extraction of the child it is peeled or torn off with the fingers. The uterus is then cleansed, and the question of disinfecting it arises. Dr. Garrigues neither sponged, washed, or disinfected the uterus in his last case, which was successful. Others have disinfected with bichloride solutions and dusted with iodoform. Dr. Justus Ohage[1] "mopped out the uterus with 1 to 4,000 corrosive sublimate and covered the whole endometrium with iodoform and boric acid." He lost his case through septic endometritis on the sixth day.

GRACE PECKHAM, M. D.

OCCASIONAL REPORT ON THE DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

Polk (W. M.) On the Treatment of Chronic Endometritis by Drainage with Iodoform Gauze.—The method is indicated in those cases in which the uterus is enlarged, its mucous membrane thickened, and the internal os more or less patulous. In its employment the cavity of the uterus is carefully cleansed, and is then packed with narrow strips of iodoform gauze, the cervical canal having been dilated when this is necessary. The gauze is to be removed after twenty-four hours, and the packing separated daily until the mucous membrane becomes healthy and its secretion normal. This treatment often renders curettement unnecessary.—*Med. News*, Sept. 29, 1888.

Johnstone (A. W.) on the Menstrual Organ.—Upon examination of sections of the endometrium with a high power, a striking analogy in structure and apparent physiological action to the thymus gland was noted; that is, that there was active formation of corpuscular cells going on during menstrual life; and that the endometrium, therefore, is to be considered as one of the cytogenic organs. Menstruation is simply the casting off of fully developed cells which are too old to take part in the formation of a placenta. The reason why a woman menstruates and animals do not, lies in the fact that in the latter the supply of lymph vessels is much greater than in the former, and the developed corpuscles are removed by them, as are corpuscles formed in other cytogenic glands. In the woman, however, the erect posture necessitates a firmer structure of the uterine body, in order that its shape may be preserved, and on account of the comparatively small supply of lymphatic vessels, the developed cells are driven into the uterine cavity and thus removed. Only the protecting layer of epithelium is removed in menstruation, and never the whole mucous membrane. The function of the endometrium is to form the placenta when impregnation occurs; and the expelled membrane of membranous dysmenorrhœa and the formation of moles are explained by the theory that an abortive

[1] Case of Sänger Cæsarean Section, *Med. News*, June 23, 1888.

attempt, excited by some irritation, at the formation of a placenta, has resulted in the production of such bodies.

The uterus is, then, not to be considered as a mere accessory to the ovaries in the matter of reproduction, but as an independent and highly important organ. Both are controlled by the sympathetic nervous system, and the fact that the menstrual function ceases after removal of the ovaries depends on the section of those nerves, which is made at the time of operation, and not because the more important organs have been removed. It is known that the closer one approaches the uterus in excision of the appendages, the more certain is menstruation to cease, and the more certain one is to cut off from the endometrium its nerve connections with the sympathetic ganglia, which control its functions.

This view as to the adenoid character of the endometrium enables one to explain the many physiological and pathological conditions which are presented for explanation and treatment, and the microscope affords the strongest evidence of its accuracy.—*Annals of Gynæcol.*, Oct., 1888.

Mundé (P. F.) on the Value of Alexander's Operation.—The results of twenty-three operations are as follows: Nineteen were successful; in two the ligaments were not found; and in two the ligaments were both torn off. Of the nineteen successful cases, fifteen have been under observation for from three months to three years and a half, and in all the uterus has been kept in position. In only seven cases was the operation performed alone, the other sixteen being preceded or followed by trachelorrhaphy, colporrhaphy, or perineorrhaphy.

The operation is indicated in cases of long-standing posterior displacements of the uterus, associated with more or less prolapsus, and with relaxation and prolapse of the vaginal walls, but only in those in which the uterus is freely movable, and cannot be kept in place by a pessary. Adhesions of the uterus positively forbid Alexander's operations. In all cases in which there is extensive injury or relaxation of the tissues comprising the pelvic floor, the operation should be followed by the plastic operation, usually performed for the relief of such conditions. The easiest method of operating is as follows: Standing on the side of the patient, opposite the one to be operated upon, the surgeon locates definitely the spine of the pubes, and putting the skin on the stretch with the thumb and finger without sliding it aside, makes an oblique incision from an inch and a half to two inches long directly down to the spine, almost nicking the periosteum. This incision slightly nicks the transverse fibres covering the external abdominal ring, and through this slit a small knuckle of fat protrudes. This marks the termination of the fibres of the round ligament. The pillars of the ring are exposed by scraping with the handle of the scalpel, allowing more fat to protrude. This is to be seized and pulled upon as soon as the outlines of the ring are clear and freed, and an aneurism needle passed under it close to the bone. The fat is then dissected away. When pulled upon, the fibres of the ligament will be seen to extend into the ring, and may be freed by the handle of the knife or finger swept around it. The ligament should be drawn out until firm resistance is felt. The operation is now repeated on the other side, the uterus anteverted and elevated on a repositor or sound, and the ligaments sutured into the wound.—*Jour. of Obstet. and Dis. of Wom.*, Nov., 1888.

Baer (B. F.) on the Treatment of Recurrent Pelvic Peritonitis.—Rest is of great importance in the general treatment, as is careful attention to the condition of the bowels. The diet should be simple and nutritious. Locally, applications of tincture of iodine to the vaginal vault and to the hypogastrium, or of boro-glyceride or idoform and glycerine to the fundus of the vagina. The hot-water douche, administered while the patient is in the dorsal position, is indispensable. After the tenderness has disappeared, very gentle massage of the pelvic organs is to be employed, at first with great care, and repeated at intervals of two or three days, the vagina being tamponed with aseptic wool during the intervals. Electricity is useful in promoting absorption of the inflammatory products. Removal of the appendages should usually be performed as a last resort.—*Med. and Surg. Reporter*, Oct. 13, 1888.

Mundé (Paul F.) on Laparotomy for the Reduction of an Inverted Uterus.—This method, as suggested by Thomas, was employed in a case of chronic inversion of the uterus, after repeated attempts at reduction by taxis had failed.

The inverted ring was dilated by means of glove-stretchers through an incision in the linea alba, but as soon as the instruments were withdrawn so as to allow of the reposition of the fundus, the ring contracted so quickly and firmly that nothing was gained by the procedure. After passing a double suture of strong silk through the fundus from the vagina into the inverted ring, and tying the vaginal ends to a piece of rubber drainage-tube to prevent laceration of the softened uterine tissues, the ring was again dilated and traction made by pulling the silk threads until the tissues suddenly gave way and the rubber tube was pulled through the ring. An elastic ligature was then tied around the uterus close to the vaginal vault, the ovaries and tubes were removed, and the wound closed. On the thirteenth day the elastic ligature had come away, the body of the uterus had disappeared, and the cervical canal was closed. The history of the case shows that even the apparently certain plan of treatment of chronic inversion by laparotomy and dilatation of the ring may be of no avail.—*N. Y. Med. Jour.*, Oct. 27, 1888.

Van de Warker (E.) on the Dangers of Galvano-Puncture in Pelvic Tumors.—The study of three cases leads to the following conclusions :

1. That galvano-puncture of pelvic tumors must follow careful discrimination of the character of the mass. That, in certain forms, cystiform degeneration is promoted to the discomfort of the patient, if not to the jeopardy of life. Tumors that appear to be solid may not be so, but may have alveolar spaces of various and irregular sizes, with interveniug trabeculæ of various thicknesses. This condition has been regarded as either the degeneration of a pure fibroid, or fibro-cyst *de novo*, or a fibroid with disseminated lymph spaces. Whatever may be the pathological condition involved, the group of tumors enumerated may prove hostile to electrolysis. We have, in such instances, the elements of cystiform evolution, which is quickly intensified by the electrolytic current. The trabeculæ separating the lymph spaces become thinned by the pressure of the accumulating fluid, and, as a consequence, the general mass becomes greatly enlarged, and, owing to the structure of the tumor, impossible to drain.

2. The fluid so accumulating may become purulent, and, owing to the segregation of the spaces, be impossible to drain, and thus render laparotomy imperative, no matter what its difficulties may be.

3. Peculiar changes may be induced in the fluid by the passage of the current, either septicæmic or ptomainic, which result in a chronic form of blood poisoning with fatal exhaustion.

4. In order to render galvano-puncture of pelvic tumors safe, special diagnostic precautions must be taken. To this end, exploratory puncture with the aspirating needle, under careful antiseptic precautions, is to be recommended. If cystiform changes are already taking place, the tumor is not a suitable one for galvano-punture.

5. The absence of pus in cases of low, persistent febrile reaction, with progressive exhaustion, points to exemption from bacterial infection of the lymph spaces of the tumor, and to the development of some other form of poison, possibly a ptomaine, due to the reducing action of electrolysis on the fluids.—*Am. Jour. Obstet.*, October, 1888.

Gehrung (E. C.) on Repression of Menstruation as a Curative Agent.—Assuming that the normal quantity of blood lost in menstruation to be just enough to restore the balance between the pressure caused by the periodical engorgement of the pelvic blood-vessels and the opposed resistance to the escape of their contents, the author argues that nature intends the amount discharged to be little in the strong and healthy woman, and none at all in her weak and anæmic sister. The menstrual flow in women of the present day is in excess of the actual want, through the depressing effects of civilization, etc., and the drain on the vital powers is too great for the health of the delicate and nervous women, who usually flow excessively. The author, in accordance with this view, has employed the tampon of absorbent cotton at the commencement of the flow, or, in the case of anæmic patients, at the first premonitory signs of the coming period. No trouble has as yet resulted, even when the flow was entirely suppressed. On the contrary, the beneficial effects were marked in proportion to the degree of suppression. The author believes that a loss of from two to four ounces will satisfy the demand in any case ; while in anæmic women all should be saved that can be saved. His rule is to limit the amount lost to that which he thinks the patient can afford to

lose.—*Jour. Obst. and Dis. Women*, Nov.' 1888.

Reed (C. A. L.) on the Indications for Removal of the Uterine Appendages.—1. In cases in which, after adequate investigation, one is assured that there is intra-tubal accumulation.

2. In cases in which, from congenital deficiency of some of the organs, there can be no healthy exercise of the menstrual function.

3. In cases of chronic ovaritis, giving rise to intolerable pain, and in which cure has been demonstrated as impracticable by conservative means.

4. In cases of irreducible displacement of the ovaries giving rise to severe pain.

5. In cases of large uterine myoma giving rise to dangerous hemorrhage, and in which the electrical treatment has failed after a reasonable trial, and finally, in which extirpation of the appendages can be practised with greater safety than hysterectomy.

6. In cases of puerperal peritonitis and intraperitoneal accumulations in which, after opening the abdomen, the appendages are found diseased.

7. In cases of intraperitoneal hæmatocele in which, on exploration, a bleeeding point is found in a ruptured tube.

8. Exploratory incision should be advised in all cases in which any of the foregoing conditions are reasonably suspected, and in all cases "of disease of the abdomen or pelvis in which the health is destroyed or life threatened, or in which the condition is not evidently due to" irremovable "malignant disease."—*Provincial Med. Jour.*, Nov. 1, 1888.

Michinard (P.) on an Unusual Case of Uterine Polypus.—A colored woman, 48 years of age, presented herself, with a large pear-shaped tumor presenting at the vulva. Eight days previously she had suffered from pains resembling those of labor, and within five days the tumor appeared at the ostium vaginæ. It had been taken for a prolapsed uterus by her physicians, and attempts at reduction had been made. The free end of the tumor, which was by far the smaller part, presented an opening resembling a dilated os, and which permitted the introduction of the finger into a canal which extended to the base of the tumor. This peculiar condition made its resemblance to an enlarged prolapsed uterus very striking, and the correct diagnosis was made only after careful examination by the absence of prolapse of the vaginal walls and the presence of a thick pedicle. No report of a similar case could be found. *New Orleans Med. and Surg. Jour.*, Nov., 1888.

The Porro and Sänger Cæsarean Sections.—The choice of method should be guided by the special requirements of the individual cases. The Porro method is preferable in cases of malacosteos and of obstruction by fibroid tumors when practicable, and when the fœtus is dead and putrid, though in such cases a fatal result is probable on account of pre-existing sepsis. The Sänger method is indicated especially when the pelvic diameters will allow of the premature birth of a viable child in case the patient should again become pregnant. The mortality of the Porro operation is greater than that of its rival, and convalescence is tedious.—*Med. News*, Dec. 15, 1880 (Editor).

Tait (Lawson) on Conclusions Drawn from One Thousand Abdominal Sections.—The statistics of a second series of one thousand operations are contrasted with those of the author's first thousand, showing a mortality of 5.3 per cent., against 9.2 per cent. of the first series. Increased experience has enabled him to make the statement that *no cystic tumor of the abdomen exists which cannot be removed; and the same is true of non-malignant tumors of every organ in the abdomen except the liver and the spleen.* Among the new operations were four for puerperal peritonitis, with a mortality of 75 per cent., and four "amputations of the pregnant uterus" (a species of Porro's operation), all successful, all of the mothers and children surviving. The removal of the uterus and adnexa is strongly recommended in cases demanding Cæsarean section, not only for the purpose of diminishing the danger of septic trouble during the puerperium, but also to make the woman sterile.—*N. Y. Med. Record*, Nov. 10, 1888.

Cushing (E. W.) on Adenoma of the Uterine Mucous Membrane.—There is a certain class of cases in which repeated uterine hemorrhages occur some years after the menopause, and end in the development of carcinoma of the body of the uterus. At first the hemorrhage is relieved by curetting, and the substance removed is to be carefully distinguished from fungoid growths by the microscope,

consisting, as it does, entirely of glands, with only enough interglandular substance to hold them together. It is a true adenoma, and at first is confined strictly to the mucous membrane of the uterine body, but later it takes on a carcinomatous character and infiltrates the muscular tissue and the uterine ligaments. The growth returns within a few months after curetting. In any case of uterine hemorrhage coming on some time after the menopause, the tissue removed by the curette should be carefully examined by the microscopist, and if this condition be found to exist, vaginal hysterectomy is indicated, and offers the only hope of cure.—*Boston Med. and Surg. Jour.*, Dec. 13, 1888.

Livezey (A.) on Complete Inversion of the Uterus.—This accident occurred in the case of a woman, aged 25, IIIpara, who was delivered of a large child while in the kneeling posture. By the efforts of the midwife to deliver the placenta by pulling on the cord while the patient still knelt, the uterus was completely inverted, the placenta remaining adherent. Attempts to replace the fundus were rendered futile by the firm contraction of the muscular fibres of the cervix. Enemata of an infusion of lobelia were given, and a dose of ten drops of tincture of gelsemium was given by the mouth. After about twenty minutes' time the cervix became soft and relaxed, and the fundus was replaced with great ease. The author believes that the use of the drugs mentioned will always be followed by good results in cases of a similar character.—*Weekly Med. Rev.*, Dec. 8, 1888.

Lee (C. C.) on the Value of Hysterorrhaphy in the Treatment of Retroflexion of the Uterus.—This operation—the "ventral fixation" of Sänger—as a primary measure, is indicated in cases of retro-positions of the uterus which are marked by the existence of firm adhesions, with or without prolapse of the ovaries, which do not yield to treatment or massage, and in which the symptoms are severe. As a secondary operation, *i. e.*, when performed at the time when abdominal section is done for other purposes, it should be employed in all cases of posterior displacements of the uterus. The technique is simple. After the peritoneal cavity is opened the uterus is freed from adhesions, using only the finger-tips in separating them, beginning with those which affect the broad ligaments, in order that no mistake may be made between adhesions and the utero-sacral ligaments. The fundus then is attached to the anterior abdominal wall by stitches of fine Chinese silk, made aseptic, and the wound closed in the usual manner. The sutures, two at each cornu of the uterus, are to be passed through the proximal edge of the broad ligament in such a manner as to encircle the round ligament,—and, in case the menopause has occurred, the tube also,—tied firmly, and then passed through the peritoneum and supra-pubic fat at the lower angle of the abdominal wound, and cut short after being tied. The histories of six cases of the primary operation show four cures, one failure (only one horn of the uterus could be brought into position on account of firm adhesion of the broad ligament on the opposite side in this case), and one as yet undecided, the operation having been done so recently that the final result was in doubt. No death resulting from the operation had been reported.[1]—*Jour. Obstet. and Dis. of Women*, Dec., 1888.

SURGERY.

Bouisson (G.) on Fatal Infectious Endocarditis and its Sequelæ Following Circumcision.—A robust railroad employé was brought to the hospital October 6th, suffering from right hemiplegia and aphasia. He had been circumcised a short time before. On October 5th, he was seized with headache and partial opisthotonos. In nine hours his speech became embarrassed. On admission he was found to have, in addition to his right hemiplegia and aphasia, a recent cicatrix, from circumcision, which was whitish near the cutaneous margin and pigmented near the mucous margin. It contained no induration. The prepuce was still partially phymosed below and contained some ammoniacal smelling, but acid reacting urine. The urine was not albuminous.

Careful physical examination failed to reveal any sign of endocarditis, so the idea of an infectious ulcerative endocarditis of pyo-urethral origin was given up and the suspicious appearance of the preputial cicatrix lent plausibility to the theory that the

[1] During the discussion of the paper Dr. H. A. Kelly, of Philadelphia, reported one fatal result of this operation.

subject was syphilitic and that the hemiplegia was due to a specific lesion. Anti-syphilitic remedies were prescribed.

On the evening of the 11th, the temperature was 100°F.; the next morning it was 103.5° and on succeeding days it ranged from 102° to 104°, one day reaching almost 105°F.

On October 14th, a typhoid condition set in, and the next day a reddish, painful tumefaction appeared about the metacarpophalangeal articulation of the left index and medius, while both palms were the seat of a rosy, erythematous, lenticular eruption not accompanied by much infiltration of the skin.

It was now thought that an infectious endocarditis existed, although the customary physical signs were still absent. Death took place on the 17th of October.

On autopsy an embolus was found in the commencement of the left sylvian artery, and the part of the brain supplied by this vessel was softened. The liver was large, the spleen large and the seat of infarctions. The kidneys were swollen and yellow and their pelves dilated. Each had infarcts. There were enormous cauliflower-like vegetations on the mitral valve, which nearly closed the auriculo-ventricular orifice.

There was found to be a pseudo-membranous urethro-cystitis.

The tumefaction on the left hand was found on incision to contain a material resembling scrapings from the spleen.

Dr. Girode found the bacillus considered pathognomonic of septic endocarditis in the cardiac vegetations and the infarcts from the spleen and kidney.

This bacillus injected into the veins of a rabbit produced a subacute, ascending spinal paralysis.

This same bacillus was found in the urethra, and also a large bacillus giving a green culture, and also the staphylococcus pyogenes albus.—*L'Union Méd.*, Dec. 13, 1889.

Bennett (C. D.) on the Diagnostic Value of Hemorrhage from the Ear in Head Injuries.—The personal observation of the author is as follows:

A man of 28 fell in an elevator seven stories. One of the large supporting beams of the cage fell after him, striking him in the face, and causing a fracture of the alveolar process of the lower maxilla. Three quarters of an hour after the accident the patient was conscious, but very irritable, and presenting no other brain symptoms. Pupils equal and normal in size. The hemorrhage was profuse from the nose and from both ears. No paralytic symptoms were discoverable.

The next day the hemorrhage from the ears continued in lessened amount, and a patch of subconjunctival ecchymosis had appeared on the left side. General condition improved. The hemorrhage ceased during the following night. Two days later a tumefaction appeared behind both ears, which had every appearance of being inflammatory, but which disappeared in two days more by the use of cooling lotions. Seven days after the injury the ears were examined by Dr. T. Y. Sutphen, who says:

"After removing the clot found in both ears I found the external canal red, and swollen slightly anteriorly and superiorly. No wound could be detected. Membrane red, but not perforated. Hearing watch four feet from each ear, or nearly normal. No hemorrhage in middle ear."

In his opinion the base of the skull had been fractured, and the blood had perforated at the side of the membrane, not through it.

This patient continued to improve, suffering only from occasional headache and vertigo, and with these symptoms continuing in steadily lessening severity, he was discharged practically well in a month.

The author concludes: That hemorrhage from the ear is, in itself, no evidence of fracture of the base, and that, even in conjunction with other symptoms, it must only be regarded as presumptive evidence. The membrana tympani should be examined, and if found intact it is pretty certain that no fracture of the base exists. He thinks that all the signs of fracture of the base may be present with mere concussion of the brain, and that therefore the two injuries cannot always be differentiated. Many recorded cases of recovery from such injuries, he thinks, were only cases of concussion. In his case the author thinks that the severe blow on the jaw drove it violently backward in such a way as to injure, perhaps fracture, the anterior wall of the external auditory canal.—*Med. News*, Dec. 22, 1888.

Piper (E. W.) on the Value of the Cupping-Glass in Depression of Parietal Bone in a Child.—A little girl of seven fell from the fire-escape, July 24, 1888, and lay in a stupor from which

they could not arouse her. I called and found the child suffering from a comminuted fracture of the skull of the left side of the head and a dislocation of the left clavicle at the sterno-clavicular articulation, besides a small depression in the skull, about the size of a silver quarter of a dollar, where the splintered bone could easily be felt.

There was a linear fracture of the left parietal bone about four inches long and depressed.

I applied a cupping-glass and made gentle traction, and was much pleased to see the depressed bone coming slowly back to its place soon as the pressure was taken off. The child partially returned to consciousness. I directed cold applications to be used to the head, and ordered small doses of the fluid extract of ergot given internally at frequent intervals.

At no time has the child's temperature been above 101°. The little patient has so far not had a single unfavorable symptom; eats and sleeps well, and is enjoying herself as usual with her playmates.—*Med. Register*, Dec. 1, 1888.

Barth (H.) on Fracture of a Rib without Apparent Complication; Sudden Death on the Ninth Day.—A healthy man of 46 fell and broke a rib on the right side. The injury was somewhat painful and there was some cough but nothing to indicate a serious condition. On the ninth day the patient complained of dyspnœa, turned pale, fainted, and died.

On autopsy it was found that the right sixth rib was broken obliquely in its anterior third. The fragments were widely separated and the costal pleura was extensively torn. The right pleural cavity contained more than three quarts of partly coagulated blood.—*La France Méd.*, Dec. 18, 1888.

Abbe (R.) on a Tuberculous Tumor Compressing the Spinal Cord; Complete Paraplegia; Operation; Recovery.[1]—The patient was a man of twenty-one, who gave no history of either syphilis or tuberculosis. Since the 1st of January, 1888, he had had slight pain in his back. On examination, nothing abnormal was found except a slight fulness of the soft parts over the ninth and tenth dorsal vertebræ, where there was some pain on pressure, as well as on motion. Dr. Kinnicutt diagnosticated tumor of the spinal canal. Dr. Ridlon believed that Pott's disease was not present, because the tenderness was confined to the spinous and right transverse processes rather than to the vertebral bodies or intervertebral discs. The patient was put under treatment with iodide of potassium, and the pain in the back was relieved by blisters. Four weeks later the swelling alongside of the tenth spinous process had increased in size so as to form an indurated mass, measuring two inches and a half by three inches. Disturbed tactile sensibility was noted in both lower extremities, and a line of hyperæsthesia could be traced extending across the lower part of the abdomen from one anterior superior spine to the other, below which line the normal sensibility was diminished. The patellar and plantar reflexes were marked. The muscular power in both legs was notably diminished. On April 27th the patient moved his legs with difficulty and could not stand without swaying and almost falling. Ankle-clonus was present. The patient complained of twitching of the legs, and they became cyanotic when allowed to hang over the edge of the bed. There were no bladder or rectal symptoms. On May 4th the patient complained of rapidly increasing weakness, with sevcre pain in the spine on moving in bed. The entire spine was rigid. Pressure on the ribs caused pain. There was entire loss of sensation in the right leg, with tenderness and hyperæsthesia over the abdomen.

On May 10th the patient was much weaker and had hectic. He complained of constant intercostal and girdle-pains. There was severe muscular twitching. Urine and fæces were retained with difficulty. On May 25th a needle was introduced deep into the tumor and pus was withdrawn.

May 29th.—The patient was etherized and an incision six inches in length was made on the left side of and half an inch from the spine, commencing opposite the sixth dorsal vertebra and terminating at the twelfth. The tissue was divided down to the lamella, and about two ounces of cheesy pus were evacuated. The lamellæ and spinous processes of the eighth, ninth, and tenth dorsal vertebræ, being carious, were removed with a rongeur forceps, revealing a mass of dense connective tissue and broken-down material which occupied

[1] See MEDICAL ANALECTIC, 1888, p. 386.

nearly the entire diameter of the canal for two inches and a half and pressed the cord tightly against the anterior wall. This was thoroughly cleared away with Volkmann's spoon. The bodies of the vertebræ were found to be covered with healthy periosteum, although pus had made its way around to the front of the vertebræ and along the tenth rib. The cavity was packed with iodoform gauze, a counter-opening having been made on either side of the spinal column and two rubber drains introduced. After thorough irrigation with bichloride solution (1 to 1,000) an antiseptic dressing was applied, and over this a plaster jacket. The wound healed rapidly, and by June 8th sensation had begun to return in the lower limbs. On the 25th the patient could move his left leg and the toes of the right foot. He had gained in weight and was free from pain. A month later he could move both legs, the flexors responding more quickly than the extensors.

August 5th.—The patient could go about the ward in a rolling chair. The wound had almost entirely healed. In the course of another month he was able to walk on crutches. At the present date (Oct. 10th) he was making steady improvement; his general condition was excellent, he had no fever, was free from pain, could move his limbs, and stand, and walk with the support of a chair.—*N. Y. Med. Jour.*, Nov. 24, 1888.

Morton (T. K.) on the Radical Treatment of Suppurating Inguinal Glands.—The chief points to be kept in mind are: vertical incision down to the gland capsules, if they still remain, avoiding, if possible, those most degenerated; to enucleate the latter from one or the other side; to remove every gland of the chain or neighborhood, whether enlarged or not, with the fingers alone, if they be unruptured, or with the curette, if that accident has occurred before or during the operation; and, finally, never to be content to open abscesses of the above septic, specific, or tubercular nature, without at the same time removing all the glands which are their present cause, or they may prove future sources of recurrence or constitutional infection.

The author advises the same treatment for suppurative, tubercular, and specifically infected glands.—*Med. News*, Dec. 22, 1888.

[Very similar views are held by Dr. H. W. Rand, of Brooklyn,[1] who has become quite skeptical as to the efficacy of external applications, parenchymatous injections, and other palliative methods.—EDITOR.]

Absence of Soft Chancres in Finland.—The community in Finland are to be congratulated upon being able to show a clean bill of health in regard to soft chancres. Dr. Petersen has stated that, while examining at Helsingfors the patients suffering from venereal disease, he was astonished to find no cases of the soft sore. Being anxious to learn a little more about this somewhat remarkable immunity from this common form of venereal disease, he interrogated Professor Senirnoff, who stated that the soft chancre did not occur at Helsingfors as a naturally developed disease. Whenever it was met with, its origin was due to importation. During the season, when the port was open to shipping, the soft chancre made its appearance among certain of the inhabitants. During the spring only a few cases were to be observed: these, however, increased throughout the summer; in the autumn, on the other hand, they began to diminish, and in winter soft chancres were never met with. The absence of soft chancre at Helsingfors is explained by the cleanliness of the Finlandish women, and by the careful medical surveillance to which they are compelled to submit. The sailors visiting the port would seem, therefore, to be the only channel through which syphilis could reach the community in this part of the world. If this assumption be correct, it would perhaps be advantageous to attempt to curtail the importation of the disease by compelling the men to submit to examination before they were allowed to mingle with the women of the town.—*Med. Press*, December 12, 1888.

Leidy (J.) on an Unique Case of Multiple Exostoses.—A housemaid, æt. 25, with a good family and personal history, comes complaining of severe pain in the left thigh and both knees due to the presence of several large hard tumors in the corresponding positions. She not only suffers pain, but at times is unable to maintain her equilibrium, necessitating the separation of her feet for some distance so as to give her a broad base upon which to stand.

The largest growth, about the size of a

[1] *Brooklyn Med. Jour.*, May, 1888.

cocoa-nut, prevents her maintaining the recumbent or sitting posture, without experiencing severe pain. The only relief is to be obtained while in the erect position. Her powers of locomotion are considerably interfered with by several growths upon the inner side of the knees. The former outgrowth she first discovered ten years ago, and she believes it to be increasing in size. The existence of the above multiple tumors, of bony consistence, upon the same individual, led to a careful examination of the whole body, which showed the presence of hard bony outgrowths varying from the size of a cocoa-nut to a grain of corn, to the number of one hundred and twenty-six, arranged symmetrically upon the following bones.

The largest outgrowths were found upon the following: Right and left femur, tibia and fibula, pelvis, left scapula, seventh, eighth, ninth, and tenth left ribs anteriorly, sixth, seventh, and eighth ribs posteriorly. Growths of variable sizes were found upon the metatarsal and carpal bones, phalanges, ulna, humerus, clavicle, ribs, ilium, and ischium. Upon the shafts of several of the long bones were elevations which conveyed the sensation as though shot had been imbedded beneath the periosteum. The bones of the skull were not affected.

The above outgrowths, variable in size and shape, were all of stony hardness, both pediculated and sessile, and smooth and irregular upon the surface.

Pain, which was the principal symptom in this case, was purely mechanical. Deep pressure failed to elicit any marked tenderness, friction of the superficial tissue on the other hand gives rise to severe pain, which radiates from the growth principally along the course of the nerves in close proximity. The pain in the knees was clearly demonstrated as due to interference.

The history of these growths is not without interest; as is usually the case they occurred insidiously without the patient's knowledge. With the exception of the one upon her thigh, she was unconscious of their existence until her attention was drawn to them. It appears almost inconceivable how such a growth, the size of that upon the scapula or the phalanges, could have existed for any length of time without the patient's knowledge.

Several of the largest outgrowths are of sufficient interest to deserve a detailed description.

The left scapula was so distorted by an irregular growth, the size of two fists, which arose from the body of the bone, that its normal contour was completely destroyed. The prominence upon the left femur consisted of a large bony outgrowth, of stony hardness, hemispherical in shape, the semi-circumference of which measured ten inches, perfectly smooth upon its surface, and attached by a broad base to the posterior aspect of the shaft of the femur, just below the trochanter. The projections from the inner condyles of both femurs and upon the tibiæ and fibulæ, mostly coracoid in shape and irregular upon their surface, extended in such a direction as to interfere markedly with the movement of the lower limbs during the act of walking. Bursæ were to be found over several of the above prominences.

The character and position of the above osseous masses, connected as they are with the epiphyses, determine them as belonging to the cancellous variety of the so-called epiphyseal exostoses by development, though we would mention in this connection their extension from the epiphyses and along the shafts of several of the long bones. In this respect they rather conform to that variety to which Poncet has applied the term juxta-epiphyseal exostoses, and such classification appears to be anatomically the more accurate.

Though cases of multiple exostoses are not rare, the above case is unique as regards the unusual number of outgrowths and the number of different bones affected; the nearest approach we can find was in a lad aged ten years, upon whom Virchow found sixty-five exostoses, following an attack of acute articular rheumatism.—*University Med. Mag*, Jan., 1889.

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THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

With the active collaboration of

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OCCASIONAL REPORT ON NERVOUS DISEASES.

BY FREDERICK PETERSON, M.D.

Jackson (J. Hughlings) on Hemiplegia.—This author, in a recent lecture upon diseases of the brain, as usual adds some original and thoughtful facts to our knowledge of this subject. He speaks of two types of hemiplegia, an arm-type and a leg-type, where either of these extremities is most disabled. In a left hemiplegia the arm-type would be preferable, because the left arm can, if necessary, be dispensed with; while in a right hemiplegia the leg-type would be preferable, since a man can better afford to lose a right leg than a right arm, and there is less likelihood of defect of speech if the leg-centre is chiefly affected.

If the paralysis begins very locally, say in the hand, and increases in degree and range very slowly, day by day and week by week, there is great probability of tumor of the opposite cerebral hemisphere. In most cases of slow hemiplegia one should treat for syphilis in the early stages. A hemiplegia following immediately upon an epileptic seizure beginning very locally would indicate cortical disease in the Rolandic region. The discharging lesion causing epileptic seizures in such cases is usually probably a local encephalitis about a tumor. The treatment of syphilitic post-epileptic hemiplegia is treatment for syphilis, of course, and also empirical treatment with bromides, the hemi- or mono-plegia itself requiring no treatment.

If hemiplegia comes on deliberately, say in half an hour, without defect of consciousness, the presumption is for local softening from plugging of the middle cerebral artery or one of its branches. If rapid with loss of consciousness, or if coma soon follows a deliberate onset, the presumption is for cerebral hemorrhage. But these rules are only empirical and have their exceptions.

The type of syphilitic hemiplegia due to a syphilitic endarteritis is not cured by drugs. After the artery is obliterated and softening occurs, drugs will do nothing toward curing the paralysis. But active treatment should nevertheless be carried on with mercurials and iodides in order to prevent similar occlusion of other vessels. There is no doubt that some of these cases of hemiplegia do recover, but not from treatment. All cases of hemiplegia, from whatever cause, that get well do so through the law of compensation by other nervous elements. This compensation will depend materially upon the smallness and position of the lesion.

As regards treatment in all classes of hemiplegia, the paralysis needs none. Massage and gentle faradization will be of some service while we are waiting for compensation, but merely as an artificial exercise. To diminish the quantity of highly nitrogenized food, to look after digestion, to keep the patient's bowels free, is the best style of treatment. If arterial tension be high give small doses of mercury and saline aperients. Never give strychnine in cerebral paralysis.

Hemiplegia is not a nervous disease at

all in the strict sense; it is in most cases an arterial affair.—*Brit. Med. Jour.*, July 21, 1888.

Starr (M. Allen) on Apraxia and Aphasia.—The author defines apraxia as inability to recognize the use or import of an object. Thus a fork, a cane, a pen may be looked at by the patient, yet no idea be awakened of its use; the sound of a bell, or a taste, or an odor, may no longer be recognized by the ear, tongue, or nose, because of the lesion in the cerebral centres of those organs. The several varieties of apraxia would be those depending upon the sense with which it is associated, such as mind-blindness, mind-deafness. In the cases he has collected Starr finds that the lesion of apraxia is always in the left hemisphere of right-handed persons, and in the right hemisphere in left-handed, as is the rule with aphasia. He tabulates nine cases of the form of apraxia known as psychical blindness, and which were asssociated with the form of aphasia termed word-blindness.

He describes five varieties of aphasia, viz., word-deafness, word-blindness, motor aphasia, agraphia, and paraphasia. Motor aphasia is a paralysis of articulation. Agraphia is a loss of the effort-memory necessary for writing. Paraphasia is due to lesion affecting the association fibres between the auditory speech centre and the motor speech centre; in this form patients understand spoken words and pronounce many words well, yet have no power of repetition, and misplace words when talking.

To examine an aphasic thoroughly it is necessary to test:

1. The power to recall the spoken or written name of objects seen, heard, handled, tasted, or smelt.
2. The power to understand speech and tunes.
3. The power to understand printed or written words.
4. The power to speak voluntarily. Does he talk clearly? Does he mispronounce words? Does he misplace words? Does he talk jargon?
5. The power to repeat a word after another.
6. The power to read aloud. Does he understand what he reads?
7. The power to write voluntarily. Can he read what he has written?
8. The power to write to dictation.
9. The power to copy.
10. The power to recognize the use of objects seen, heard, felt, tasted, or smelt.—*Med. Record*, Oct. 27, 1888.

Snow (Irving M.) on Chorea.—This author gives an excellent summary of our latest information regarding this disease. He mentions the rheumatic nodules of Barlow often found in these cases. They consist of small subcutaneous lumps appearing upon tendons or ligaments, and generally having their seat on the scalp, along the spine or about joints. They appear and pass away with the disease, and are nearly always associated with endocarditis. He had seen a remarkable case of this kind recently, where the nodules were as large as horse-chestnuts, and were found above both ears, on the occiput, along the spine, and on the ankles, knees, and wrists. They were not tender and passed away with the chorea which was of a mild type.

The author quotes Dr. A. McL. Hamilton as an authority for the rather remarkable statement that twenty per cent. of the school children of New York City suffer from chorea.

The treatment advocated by Dr. Snow is that usually in vogue; recumbence and arsenic. He states that Barlow practises mild hydropothy with success, douching the patient with lukewarm or cold water, the child being subsequently rubbed and put to bed. M. Legroux gives antipyrine in large doses, up to forty-five grains daily, and reports astonishing success.—*Buf. Med. and Surg. Jour.*, Nov., 1888.

Lees (David B.) on Two Cases of Hysteria in Boys.—The first boy was eight years of age and of a neurotic family. There was dysphagia and spasmodic adduction of both legs lasting some weeks. The superficial reflexes and cutaneous sensibility were normal, but the knee-jerks were exaggerated. He had to be forcibly fed. Finally he recovered under regularity of diet and the moral treatment of turning a deaf ear to his complaints and encouraging him to exert himself.

The second boy was eleven years of age. He had headache and anæsthetic areas on his left cheek, trunk, and limbs. There was also amblyopia of the right eye and defective hearing in the right ear. Two months later there was a transfer of the anæsthesia, together with analgesia to the right side of the body; and two months subsequent to this a second transfer to the left side again.

The boy also was found to have double nasal hemianopia, the rarest of all forms of hemianopia. This lad had improved very much at the last note taken, five months after the first examination.

The author contrasts these two cases, the one with its symptoms purely motor and the other with derangement in the sensory sphere, and suggests that some kind of torpidity of the cortical nerve centres, influencing different areas, is the cause of the symptoms. The designation of such cases as hysteria is of course absurd, implying as it does the influence of an organ which the male sex does not possess.—*Lancet*, June 9, 1888.

Leszynsky (Wm. M.) on Pupillary Phenomena in Nervous Disease.—The normal pupils should be mobile and of the same size and shape. Place the patient facing a window, and do not allow the sun to shine in his face. Do not examine the pupils directly in front of a gas flame or with the patient's back to the light. Direct the patient to look at some object at least twenty feet distant in order to relax accommodation.

The pupils are *contracted* when the eyes are exposed to a bright light and generally also in persons over fifty years of age. Myosis under fifty years of age is almost always pathological. They are contracted in cerebral hyperæmia, in the early stages of meningitis, and in hypermetropia. Eserine, morphine and pilocarpine contract them. Irritation of the third nerve from its nucleus to its periphery, or paralysis of the sympathetic, contracts the pupil. Myosis is often observed in locomotor ataxia and general paresis, occasionally in cervical myelitis.

The pupils are *dilated* in darkness or subdued light. In an old person dilatation is pathological. Exaggerated nervous excitability produces it often in children and grown persons. Mydriasis is produced by atropine, duboisine, and hyoscyamine. In high degrees of myopia there is often dilatation, and often in cerebral or general anæmia. Irritation of the sympathetic or paralysis of the third nerve produces dilatation of the pupil on the side of the lesion. It takes place in epileptic coma, amaurosis, high grades of optic neuritis and in excessive intracranial pressure.

The *shape* of the pupil varies, being distinctly different in each eye at times; or both may be alike, yet irregular. Sometimes one is round and the other pear-shaped, or triangular, or somewhat vertical or horizontal. The irregularity may be due to adhesions from a former iritis. The condition known as coloboma may be congenital or due to surgical operation. Unequal pupils never occur in health, but are observed where there is marked difference in the degree of refraction in the two eyes. They are present in general paresis. Unless the inequality is pronounced there may be difficulty in determining whether one is dilated and the other contracted. Unilateral dilatation may be due to local eye disease, to some drug, to paralysis of the third nerve, to irritation of the sympathetic, or to blindness of that side. Unilateral contraction may have its origin in iritis, irritation of the third nerve, paralysis of the sympathetic, or in drugs. Either phenomenon may be present in an attack of migraine.

The *mobility* of the pupils should next be considered, their direct reflex to light, their indirect reflex to light, or their consensual contraction; and thirdly, their associated contraction in accommodation. To examine the consensual reaction, one eye is covered for a moment and then suddenly exposed, when contraction will be seen to take place in both pupils, owing to bilateral association of the reflex mechanism. To examine the associated contraction to accommodation, have the patient look at an object within a foot of the eyes, his previous gaze having been toward some object twenty feet or so away, when synchronous contraction of both pupils will be observed. In health the pupils dilate upon pinching or scratching the skin of the neck, owing to irritation of the sympathetic fibres connected with the cilio-spinal centre. Reflex action to light is lost when there is blindness from diseased optic nerves or retinæ. If only one eye is blind, the direct action of its pupil will be lost, but the consensual reaction will be preserved. Loss of reaction to light during an epileptic fit is positive exclusion of simulation. The Argyll-Robertson pupil is one where the reflex to light is lost, but that to accommodation normal; it is found in locomotor ataxia, general paresis, and in some cases of multiple sclerosis.—*N. Y. Med. Jour.*, March 31, 1888.

Sachs (B.) on Progressive Muscular Dystrophies.—From his admirable paper on this subject the author makes the

following deductions, which are an important exposition of our present knowledge relating to the muscular dystrophies:

Progressive muscular atrophy, type Aran-Duchenne, is due to spinal-cord disease. The peroneal type bears a close resemblance to this form, and may possibly have the same pathology. Duchenne's form might be termed the hand type, and the peroneal the leg type. Pseudo-hypertrophy is not of spinal origin, and lipomatosis is a mere incident in its course, associated with widespread atrophy in various parts of the body. There is a close relation between pseudo-hypertrophy and Erb's juvenile form of progressive muscular atrophy, but no absolute identity. All forms of primary myopathy are occasionally hereditary; hence, hereditary muscular atrophy does not deserve the rank of a separate clinical entity. The type Landouzy and Déjérine is closely related to Erb's form, the involvement of the facial muscles not sufficing for wide clinical differentiation. Pseudo-hypertrophy and Erb's form should be regarded as the two representative forms of primary progressive dystrophies. The latter are distinguished from the spinal progressive dystrophies by the occurrence of true or false hypertrophy, the absence of the reaction of degeneration, and the absence of fibrillar contractions. He would classify muscular atrophies as follows: 1. Amyotrophia spinalis progressiva. *a*. Hand type; *b*. Leg type = peroneal form. 2. Primary progressive dystrophies. *a*. Pseudo-hypertrophy; *b*. Erb's form.—*N. Y. Med. Jour.*, Dec. 15, 1888.

Anderson (T. McCall) on the Diagnosis and Treatment of Syphilitic Affections of the Nervous System.—Positive evidence of syphilis is of great value, but negative evidence should not divert us from our suspicion, if, for other reasons, a syphilitic basis is probable. In thirteen cases the interval between the syphilitic infection and the outbreak of nervous disease varied from two and one half to thirty years. The nervous system generally suffers in the late stages of syphilis; where it is implicated in the second stage, evidences of the disease will almost certainly be found on the skin and mucous membranes. In the second stage we look for tubercular eruptions, serpiginous ulceration, subcutaneous gummy tumors, deep ulceration of the palate or of one side of the throat, syphilitic disease of the tongue (which must not be confounded with tylosis linguæ), periostitis, and enlargement of a testicle.

The traces of bygone syphilis are a cicatrix upon the penis, usually slight, and not otherwise satisfactorily accounted for; circular cicatrices upon the skin, with sharply defined edges, and often with coppery areolæ (specially valuable if not below the knee); scars at the angles of the mouth or on the palate or fauces; perforation of the septum nasi, atrophy of a testicle, or indurations upon the superficial bones.

The presence or history of pain in the joints, bones, or head is a very suspicious feature if markedly worse at night. It may almost be said that pain which is agonizing at night and disappears by day is pathognomonic of syphilis.

Syphilitic affections of the nervous system are met with at all ages, but most usually at or before middle life.

The author agrees with Buzzard, who says that "putting aside cases of injury, hemiplegia or paraplegia occurring in a person between 25 and 45 years of age, which is not associated with Bright's disease, nor due to embolism (from disease of the cardiac valves), is, in at least 19 cases out of 20, the result of syphilis."

Syphilis is said by Lancereaux to affect the nervous system more frequently in members of the learned professions than in any other class, and the author is inclined to agree with his statement.

The multiplicity of the syphilitic nervous lesions is one of its chief characteristics, two or more separate lesions often co-existing. Another feature is a frequent variability in the symptoms of a brain lesion.

There are two fundamental types of cerebral syphilis according to Heubner, viz.:

(*a*) Psychical disturbances, with epilepsy, incomplete paralyses (seldom of the cranial nerves), and a final comatose condition, usually of short duration. This type usually depends upon the presence of a gumma in the subarachnoid space of the convexity of the cortex, which secondarily attacks the brain, and leads to softening of the subjacent parts; or upon diffuse gummatous meningitis.

(*b*) Genuine apoplectic attacks, with succeeding hemiplegia, in connection with peculiar somnolent conditions, occurring in often repeated episodes; frequently phe-

nomena of unilateral irritation, and generally at the same time paralyses of the cerebral nerves. This form is generally due to syphilitic disease of the arteries, leading to their obstruction and to softening of the motor ganglia, especially of the lenticular and caudate nuclei. It is often accompanied by a new growth, commencing in the membranes at the base, and extending into the interior of the brain.

As regards treatment, in all cases where there is a suspicion of a syphilitic basis we should give the patient the benefit of the doubt, and put him upon anti-syphilitic remedies. We should use iodide of potash, beginning with 10 grains thrice daily, and steadily increasing to two ounces daily if necessary. In some cases the iodide fails, and mercury proves advantageous. He prefers the inunction of the mercurous oleate ointment to any other form of the drug.—*Brit. Med. Jour.*, Sept. 29, 1888.

Knapp (P. C.) on Concussion of the Spine, Railway Spine, and Railway Brain.—The author gives the details of eleven cases whose central nervous symptoms followed injury, and draws the following inferences: Concussion of the spine, although probable, is a matter of doubt. Muscular strain, spinal irritation, and peripheral neuritis are not uncommon complications. Injuries may give rise to gross mechanical lesions, but also to chronic insidious degenerative processes, and, furthermore, to functional affections, such as the psychoses and hysterical and neurasthenic states. Both hysteria and neurasthenia may be so superimposed upon organic disease as to obscure diagnosis.—*Boston Med. and Surg. Jour.*, Nov. 1., 1888.

Fisher (E. D.) on Epilepsy Following Cerebral Hemiplegia.—The author bases the following conclusions upon twenty-eight cases detailed in his paper:

Imbecility or idiocy and epilepsy existed in all of his cases. The hemiplegia was mostly congenital in origin, or occurred within the first three years of life. In all of his cases the muscular atrophy as compared with that of spinal paralysis was slight, and due only to disuse. Where there were choreiform and athetoid movements, the muscles were well-developed. As regards longevity, the average of 20 years, as given by Henoch, was far exceeded in the author's cases. As to the epilepsy, he considers it to resemble the idiopathic variety rather than the Jacksonian form, contrary to what one would anticipate from the localization of the lesion. The inference he believes justified by analogy, that the seat of lesion of idiopathic epilepsy lies in the cortical cells, and consists of a primary change in their nutrition. Trephining in such cases as his would seem useless; but where the seizures are excessive and unilateral, the removal of some portion of the cortex has proved beneficial in some cases. The bromides seem as efficacious in this as in other forms of epilepsy.—*Jour. Nerv. and Ment. Dis.*, Sept., 1888.

REPORT ON RECENT CASES OF TREPHINING FOR INTRACRANIAL HEMORRHAGE.

BY CHARLES A. POWERS, M.D.

Mr. Thornley Stoker relates[1] a case of subcranial hemorrhage treated by secondary trephining. The patient was a man aged fifty who was received into the Richmond Hospital four days after he had fallen from a cart and sustained such injury that he became insensible.

At the time he came under observation he was in a state of stupor, with left brachial monoplegia and a partial paralysis of the facial nerve on the same side. The left leg showed a barely detectable motor insufficiency; there was no sensory paralysis, and the pupils were responsive and symmetrical. A bruise simulating depressed fracture existed in the scalp over the upper part of the right fissure of Rolando.

On the ninth day the man became worse, and was evidently dying. He was completely hemiplegic on the left side, profoundly comatose, could swallow in the most imperfect manner, and breathed, with stertor, only twelve or fourteen times in the minute. The conclusion come to was that the symptoms were probably due to hemorrhage between the bone and dura mater, dependent on a laceration, with or without fracture, of the middle meningeal artery.

In view of the inevitable death of the patient if not relieved by treatment, it was determined to trephine him. This was done on the 21st of June, the day on which he exhibited the pronounced con-

[1] *Dub. Jour. Med. Sci.*, Sept., 1888.

ditions just described, and the ninth after his accident.

The patient was completely comatose, and no anæsthetic was used. The injury over the fissure of Rolando was taken as the point indicated for operation, because, although not in the centre of the engaged portion of the motor area, a possible fracture existed there. A trephine with a diameter of 26 mm. was applied, and on the disc of bone being removed, the antero-inferior edge of the opening disclosed the edge of a well-formed blood-clot. A second trephine opening was made immediately below and in front of the first, and an oval opening measuring 52 mm. rendered available for removing the clot. At its centre the clot was so thick that the dura mater was distant from the cranium about 40 mm. Before the patient was taken off the operating table he moved his left arm and leg with tolerable freedom.

An uninterrupted good recovery was made.

[Mr. Stoker adds, that if another case resembling the above should offer for treatment he would consider the propriety of making a counter-opening for drainage at the nearest accessible point to the lower edge of the line of separation between the cranium and dura mater.

This procedure was adopted in a case which fell under the care of the collator in 1886, and the measure was strongly recommended in an article published by him in the *N. Y. Med. Record*, June 4, 1887.]

Dr. C. B. Ball relates [1] the following case of traumatic aphasia successfully treated by trephining, and removal of a blood-clot from the interior of the cerebrum. F. B., æt. twenty-six, admitted September 1, 1887, had been struck on the head with a penknife ten days before coming under observation. Since the accident he has found difficulty in using the right words,—for instance, he said he had a "man" in the side of his head, when he meant "pain." Upon examination a small scab was found adherent to the scalp, over the squamous portion of the left temporal bone; this, when detached, showed a cicatrix, apparently extending deeply through the temporal muscle, but the wound was quite healed. He was unable to name correctly articles which were shown to him, while in speaking he constantly used wrong words or parts of words. There was no paralysis whatsoever to be detected of any of the voluntary muscles when he came under my observation. Five days after his admission his symptoms had so much increased that it was determined to operate. A flap was turned down, including portion of the temporal muscle, and containing in its centre the cicatrix; this disclosed a wound of the squamous portion of the temporal bone of a size and shape likely to be produced by the small blade of an ordinary penknife. A medium-sized trephine was now applied, and a circle cut out, containing in its centre the cut in the bone; this was attended with some difficulty, as the lower part of the circumference was exceedingly thin, while the upper portion was tolerably thick; the piece was, however, removed without injury to the dura mater by the trephine. It was found that the knife had perforated the dura mater and brain. The wound in the dura mater was enlarged, in doing which the large posterior branch of the middle meningeal artery was divided, and gave some little difficulty to control. A sinus forceps was gently passed along the brain wound, and the blades separated, when a dark-colored blood presented, and was gradually extruded by the internal brain pressure. Some more fragments of clot were removed by the sinus forceps, and by a stream of weak perchloride of mercury solution from a syringe. A drainage tube having been introduced, the flap was replaced and held in position by deep sutures. On the evening of the same day the patient was much more rational. Next morning he was again more aphasic, and it was found that the drain had become blocked. Upon freeing it a considerable quantity of broken-down blood-clot was removed, and his power of speech improved. He made an uninterrupted recovery.

Dr. G. A. Bodamer, Resident Physician at the German Hospital, Philadelphia, reports [2] the following case of trephining for hemorrhage from middle meningeal artery:

A. R., aged 18, was admitted to the German Hospital December 17, 1886, with pistol-shot wound over the left temporal region.

Upon probing for the bullet the external table of the skull at the point corresponding to the wound in the scalp was found

[1] *The Medical Press*, June 20, 1888.

[2] *Med. News*, March 26, 1887.

denuded of its periosteal covering and slightly roughened. The patient at the time of admission presented no head symptoms. The wound was dressed antiseptically, and the patient was placed in bed. The next morning Dr. Bodamer noticed that symptoms of aphasia had developed, and he notified Dr. Deaver, the attending surgeon on duty, of the nature of the case.

Upon the arrival of Dr. Deaver the patient was taken into the clinic, and in the presence of the class was etherized and trephined over the lower extremity of the fissure of Rolando.

The trephine included the roughened portion of the skull. Upon removal of the section of bone, the internal table was found to be fractured with no depression of the fragments.

Upon the dura mater at this point was seen a clot of blood caused by hemorrhage from the middle meningeal artery. This was removed, catgut drainage was placed under the flap, the flap adjusted but not stitched, and the part dressed antiseptically.

As soon as the patient recovered from the effects of ether, no symptoms of aphasia remained, and he was again able to converse.

On the morning of the day of operation the temperature was 100° F., the following morning was 98.3° F., and remained from that time normal. He was discharged cured January 22, 1887.

Mr. Edmund Owen relates[1] the following case of subdural hemorrhage, localization, trephining, recovery :

On May 8th W. MacC., a well-grown boy of 9 years, was brought to St. Mary's Hospital, stunned by a fall from a cart. He vomited profusely, and turned his head from the light. The pupils were equal, and acted to stimulus. No fracture of the skull could be detected. The movements of the limbs were perfect. He was very drowsy. Next day (the 9th) he answered questions occasionally, was extremely restless, frequently muttering, and jumping out of bed. Temperature, 101°.

Until the 13th there was no material change, but on that day convulsions set in. The first fit was at 7 A.M., and lasted about half an hour, the right facial and suprahyoid muscles acting in a tumultuous and energetic manner.

Next day, May 14th, the temperature was normal, pulse 72 ; he had several slight fits, but towards night he had a most severe attack, lasting nearly two hours ; and, in addition to the muscles already mentioned, the diaphragm and the right sterno-mastoid worked spasmodically. The flexors of the right wrist and fingers contracted violently about ninety times a minute. The boy did not lose consciousness during the fit, but he was unable to speak.

May 15th. Though he had had no more definite attacks since the severe one of the previous night he was still aphasic, though conscious, and twitchings of the muscles of the right side of the face and of the right forearm and hand persisted. At 4 P.M., the hair having been some time previously removed, and the scalp rendered aseptic, ether was administered, and as the boy came under its influence the facial twitchings ceased. The position of the fissure of Rolando was marked on the wet scalp with an aniline pencil by a line drawn from the vertex, immediately above the external auditory meatus, to the depression just in front of the meatus ; this line was prolonged on to the masseteric region, so that during the operation the surgeon might always have an index to the position of the fissure. A crescentic flap of the scalp was then turned up, and a disc of bone an inch in diameter having been raised, the dura mater was exposed, of a somewhat greenish hue, and bulging into the gap. When this was incised a considerable amount of dark fluid blood escaped, and the upper border of a solid clot was exposed at the lower part of the incision. The trephine was therefore again applied, and a half circle of bone removed at the lower part of the opening. The incision in the dura mater was also prolonged downward, when the clot was thoroughly exposed and removed. It was estimated to measure about half a fluid ounce.

The space was washed clean with plenty of warm carbolized water, and sutures having been inserted, a dry mercuric dressing was applied. The boy had a quiet night, but in the morning (May 16th) he had a severe seizure, which lasted nearly two hours. The same muscles were attacked, with the exception of those of the arm and the diaphragm. When the spasm passed off, however, the boy was quiet and conscious, and far less irritable, but aphasic. Temperature 101 °.

May 17th. Pulse 82, temperature 99° F.

[1] *Brit. Med. Jour.*, Oct. 13, 1888.

but at mid-day he had a severe fit (the second since the operation), the pectoralis major and most of the other muscles of the right upper extremity being also involved. As a further extravasation was suspected, it was agreed that the wound, which had almost entirely healed, should be reopened. No blood was found in the subdural space, but on incising the arachnoid, which, covered with healthy granulations, was bulging towards the trephine wound, a small quantity of dark fluid blood escaped. The subarachnoid space was then freely irrigated, and the wound was dressed as before.

On the second day, after a severe effort, he could shake hands, and three days later, after similar efforts, he succeeded in getting out a few words. Gradually speech and complete muscular power returned; the wound healed without delay. After the second operation the temperature was never above normal until he was discharged cured, on June 15th.

Mr. Darien-Colley reports[1] a case of closed middle meningeal hemorrhage; trephining; recovery. A man fifty years of age fell a distance of twelve feet, striking the side of his head. He was insensible at the time, but recovered consciousness. He then had slight paralysis of the left arm, and bruising of the right temporal region; there was no indication of fracture. An hour afterwards he had complete paralysis of the left arm and slight loss of power in the left leg and side of the face. Next day there was noticed a little numbness on the left side. The day after the facial paralysis had almost completely disappeared, and the patient could move the left leg, but the tongue was protruded with difficulty. He continued in much the same condition for ten days. On the eleventh day Mr. Colley decided to wait no longer, so he trephined just in front of the middle of the right fissure of Rolando, using a semicircular flap. He came down upon the centre of a large clot, which he removed partly with the finger and partly by irrigation with perchloride of mercury. There was no suppuration, and the patient recovered rapidly.

Dr. S. T. Armstrong makes the following most interesting and valuable contribution[2] to this subject, the case being one of intermeningeal hæmatoma with hemiplegia; trephining; recovery.

George Jones, negro, aged fifty-three years, a native of Virginia, shoemaker by occupation, on February 27, 1887, was struck on the left forehead by a brick, the edge of the missile producing an irregular, lacerated wound, about one half an inch above the external edge of the eyebrow. He was unconscious for a short time.

On the morning of February 28th, his general condition was good. Probing detected no denudation of, or other injury to, the skull. The wound was dressed antiseptically. There was no subsequent malaise, though slight annoyance from roaring in the left side of the head; he walked half a mile to office, when subsequent dressings were required; and the wound having healed by granulation, he was discharged, recovered, on March 14th.

He consulted Dr. A. again on April 24th, stating that the roaring in the head had continued, and that on April 18th, while walking, he suddenly noticed a tendency of the right foot to drag slightly. On the 19th, while eating breakfast, his head fell forward on the table, and his right arm and leg seemed paralyzed; that morning he had a slight chill followed by fever. Since the 19th the right foot dragged a little more, and he would notice an occasional loss of control of the muscles of the right leg and arm.

At this examination the presence of *arcus senilis* was noticed; the pupils were small but responded well to light. In walking he dragged the right foot slightly. On April 26th, the paralysis of the lower extremity was more marked, and on the 28th the right arm was found to be less powerful than the left. The symptoms, as presented, had evidenced a cortical cerebral lesion, affecting the middle frontal convolution (which lay beneath the site of the original injury) and extending upward and backward, gradually involving the ascending frontal convolution.

On May 1st, anæsthesia was produced, and a curved incision made, the convexity toward the eyebrow, and the incision extending upward on the scalp so that, if necessary, it could be continued to a point over the upper portion of the ascending frontal convolution, if the operation demonstrated no lesion over the middle frontal convolution, and trephining would have to be repeated higher up. Galt's tre-

[1] *Lancet*, March 31, 1888.
[2] *Jour. Am. Med. Asso'n*, June 18, 1888.

phine applied, and the button of bone removed. A small branch of the meningeal artery presented on the dura mater, and hemorrhage from it was controlled by applications of hot water.

No intracranial fracture of the bone was found. The dura-mater was dark-colored, and had no communicated pulsation from the brain. The long needle of a large-sized hypodermic syringe withdrew dark-brown blood. Removing the needle, similarly colored blood was ejected from the puncture in the dura-mater, and with a bistoury the hole was slightly enlarged, permitting the pulsations of the brain to throw out the fluid in larger quantities, until it was almost evacuated. Four strands of disinfected horsehair were passed through the dural incision in order to secure drainage, boracic acid applied to the wound, the flaps replaced, and the head dressed antiseptically. All symptoms quickly disappeared, and the patient made a rapid and complete recovery.

Dr. H. O. Walker, of Detroit, Mich., reports[1] a case of intracranial hæmatoma with hemiplegia; trephining; recovery.

Joe S., aged thirty-five years, was brought to St. Mary's Hospital February 11, 1887, having been picked up the night previous by the police and put in the station, being registered as a common drunkard. It was with some difficulty that he could be aroused. The only information that could be gotten from him was that he had pain in the left shoulder. A careful examination of his entire body failed to give evidence of injury. There was paralysis, not complete, of the left arm and leg, with incontinence of urine; pulse 40, respiration 12, and temperature 98° in the axilla. The pupils responded to light.

February 14th. Condition the same, with the exception that the paralysis was becoming more complete and it was more difficult to rouse him.

Dr. Walker, feeling that the patient was suffering from compression of the brain, evidently due to a blood-clot, decided to trephine.

The point determined upon was midway over the right fissure of Rolando. After producing anæsthesia with chloroform, a free crucial incision was made through the scalp and similarly through the periosteum, reflecting it back from the skull. On removing the first button of bone a dark mass of coagulated blood protruded through the opening, and in order to facilitate the better removal of coagula another button was removed, and the projecting bone on each side chiselled away, thereby making a good-sized oval opening, through which was removed four ounces of coagulated blood. The cavity was thoroughly irrigated with bichloride and packed with a continuous strip of iodoform gauze, leaving a piece of it projecting from the most dependent portion of the wound, which was closed with a continuous catgut suture. Before the patient was taken from the operating table there was manifest return of motion in the arm.

He made a complete recovery.

Schneider, of Königsburg, in the *Archiv für klinische Chirurgie*, Bd. xxxiv. Heft 3, publishes[2] an account of a case of punctured wound of the skull, followed by aphasia and hemiplegia, in which he trephined and removed an intradural blood-clot from an opening in the middle cerebral artery, and effected a cure.

The patient was a young man, eighteen years old, who was stabbed with a knife in his left temple, and who had, almost immediately, paralysis of the right side of the face and of the right arm and leg. Four days afterward he was brought into the hospital in Königsberg. He then had a small, almost healed, wound over the third frontal convolution. He was perfectly conscious, and could answer by signs, although he could not speak a word. As the hemiplegia increased without febrile symptoms, Schneider attributed it to an accumulating extravasation of blood, and operated for its relief on the ninth day after the injury. He trephined the skull at the seat of the wound, opened the dura, removed a small clot, found the first branch of the middle cerebral artery spurting in the substance of the brain, seized it with forceps and ligated it with catgut. The wound was then cleansed, the opening in the dura was sutured with fine catgut, the soft parts covering the skull were also sutured, a drainage tube was inserted, and a Lister bandage was applied. The wound healed by first intention. On the third day after the operation the patient began to articulate, and in four weeks he spoke perfectly. Part of the hemiplegia disap-

[1] *Med. and Surg. Reporter*, June 9, 1888.

[2] Quoted in *Med. News*, April 9, 1887.

peared more rapidly, the leg and arm recovering in eight days; but the facial paralysis was not wholly gone after a lapse of six months.

The brilliant results obtained in the foregoing cases emphasize the necessity of careful observation of all symptoms in obscure cranial injuries, and the importance of an early resort to radical surgical procedure.

By way of contrast may be cited the following case—supradural hemorrhage; temporary measures; death—which is courageously reported by Dr. David Gardner in the *St. Louis Courier of Med.*, October, 1886.

On Saturday, September 4th, Thomas Calvard, æt. thirty-three, was struck two blows with the barrel of a shot-gun, one blow falling over the left parietal eminence, not breaking the scalp, the other blow being also on the left side of the head, about one and one half or two inches from the median line of the head over the fronto-parietal suture. The scalp was penetrated to the periosteum over the posterior edge of the frontal bone. He was knocked down by the second blow, regained consciousness. was able to sit up in the wagon and to walk down a steep hill. Complained of his breast and head, and seemed to appreciate that he was dangerously injured; was intoxicated at time of receipt of injury.

Sunday, September 5th, very restless, lying first on one side then on the other, his limbs in a state of flexion. He could be aroused by shaking and speaking to him in a loud voice, but relapsed again into a semi-comatose condition.

No paralysis was observable; no fracture of the skull could be felt at or near the wounds. The pupils were dilated.

On the afternoon of this day he passed into a comatose state. Convulsions followed, and the respiration was stertorous. Pulse 52°, full, strong, and regular. The patient remaining in this condition on the following day, Dr. G. called consultants, and it was decided to postpone operative procedure for twenty-four hours. In the meantime, however, the patient died.

The autopsy revealed a fracture of the parietal bone two inches above its lower border. There was a large clot beneath this fracture, between dura and skull, but no lesion of the brain.

Dr. Gardner frankly states that one of the surgeons felt certain that there was a clot beneath the skull, and advised trephining, but declined to take the responsibility on himself when an operation was tendered to him by his colleagues.

The above cases sustain the opinion expressed by the collator some two years ago regarding the site at which the trephine should be applied: "In almost every case of middle meningeal hemorrhage the surgeon will, I think, meet some part of it if he trephine at the junction of the middle and lower thirds of Rolando's fissure."

MEDICINE.

TRANSLATIONS AND ABSTRACTS BY WALTER VOUGHT, M.D.

Clinical Observations on Calomel as a Diuretic and Hydragogue.—Observations on twenty-seven different cases, in which the author has made use of calomel, form the basis of an interesting article.[1] These cases were: nine of hydrops from cardiac insufficiency in consequence of valvular lesions; six of diminished cardiac power from primary disease of the muscles; two where cardiac insufficiency was complicated by nephritis; one of renal and two of hepatogenous hydrops; in the remaining seven cases no hydrops was present. These were: one of pericarditis and pleurisy following acute rheumatism; one of simple pleurisy; one of gout, with contracted kidneys; one of mitral insufficiency; an old apoplexy, and left hemiplegia; finally, an enlarged spleen, of unknown origin.

Mercurialization was prevented by gargling with chlorate of potash, and by combining opium, gr. ½, with calomel, grains 3. He sums up his observations as follows:

Calomel is a diuretic, whose action is more marked than any other known drug. Its diuretic property is often seen to a slight degree in non-dropsical conditions, to a marked degree in certain forms of dropsy, and is most marked in dropsical conditions dependent upon cardiac trouble, be this in consequence of valvular disease or of primary disease of the cardiac muscle.

This diuretic effect is but slight or wanting when the cardiac insufficiency has reached the highest degree, but here other means are also useless.

The calomel treatment is of less use in hydrops from other causes, and, according to the author's experience, in portal ob-

[1] *Deutsche Archiv für klinische Medicin*, 1888, xliii.

struction, and especially in hydrops from chronic parenchymatous nephritis.

In the combination of cardiac with chronic renal disease, the diuretic effect is obtained when the cardiac trouble is the principal one. The disappearance of the cardiac dropsy is brought about both by increased diuresis and by an increase of the intestinal secretion. The more marked the former is the greater will the general result be, but good results are obtained when the amount of water passing off through the intestine approaches to or equals the amount excreted by the kidneys. If the extra-renal excretion exceeds the renal, a slight diminution in the body-weight takes place; the general good result is, however, not obtained.

If the drug acts promptly as a hydrogogue, it acts favorably on the general condition and appetite.

In exudative processes (pleurisy, pericarditis) it has none or but slight diuretic, and therefore no curative, effect.

The unpleasant effects of the drug—salivation, stomatitis, diarrhœa, etc.—can be prevented by prophylaxis, or limited in their unpleasantness in all cases where diuresis is obtained. If the diuretic effect is not obtained, symptoms of mercurialization almost always appear. For this reason it should only be given in suitable cases.

Digitalis and other diuretics have less effect on this excretion of urine, but calomel can not take the place of digitalis, as it possesses no cardiac tonic properties.

Regarding the dose, the author found three grains three times during the day to be the most suitable. This must be continued at least three days, and may even continue for twelve days. The desired effect is shown mostly on the second to the fourth day, seldom earlier or later. The polyuria lasts, in the favorable cases, at least three days, mostly four to five, and at times twelve days. The author considers the calomel to have a direct influence upon the secreting epithelial cells of the kidney. —Stitzing in the *Fortschritte der Medicin*, 1888, No. 24.

Purulent Pericarditis Successfully Treated by Aspiration and Drainage.—At a meeting of the Clinical Society of London [1]—in November last—Dr. Dickinson related the history of a boy aged ten, who manifested symptoms of pyæmia following a gluteal abscess. On admission to the hospital there was evidence of effusion into the left pleura and the pericardium. "There was much dyspnœa, blueness, and irregularity of pulse. There was œdema more or less general, but especially marked about the thorax. The liver was enlarged or depressed so as to reach the umbilicus."

The pleura was aspirated on four different occasions, with but slight amelioration of symptoms. Fifteen days after admission the pericardium was aspirated, one ounce of creamy pus being withdrawn; the operation was repeated eight days after, when twelve ounces, and seven days after this when nineteen ounces were withdrawn. The place selected for puncture was on the right side, close to the edge of the sternum, in the fifth interspace. The heart, previous to each operation, had been drawn to the left by a preceding aspiration of the pleura. One week after the last aspiration the pericardial sac had again filled up, when an incision was made in the spot of previous puncture, and a drainage-tube inserted. Recovery was complete. Mr. Parker, at the same meeting, reported a case of the same disease, which he had freely incised. Death had occurred while irrigating the pericardial cavity in order to wash out the thick membraniform pus with which it was distended. Aspiration had been previously done, with but temporary relief. He advises the fourth left intercostal space, close to the sternum, as the most appropriate place for incision, as it would longest afford a direct communication with a gradually retracting pericardium. Dr. S. West remarked that Dr. Dickinson's case was only the third case on record where recovery had ensued. The first case was published by Rosenstein, in 1881; the second (the speaker's own), published in 1883 or 1884. Dr. Barlow, alluding to the question as to the best position to perform aspiration, quoted two cases that had died unrelieved, in which he had made the autopsies. All the experimental punctures made to the left of the sternum went into the heart wall, and he was unable to withdraw any fluid by the aspirator, and was only successful when he introduced the needle to the right of the sternum. He was disposed to consider that the right-sided puncture had been unnecessarily discarded.

Rosenbusch (L.) on Cresote Injections in Pulmonary Tuberculosis.—

[1] *Brit. Med. Jour.*, Dec. 1, 1888.

From a large number of cases of pulmonary tuberculosis in which the author has made parenchymatous injections of creosote into the lung most excellent results have been obtained. A three-per-cent. solution of creosote in almond oil was used as injecting fluid. A quarter of an hour after the injection, cough disappears; five to eight hours after, a fall in temperature, lasting twenty-four hours, occurs. After a number of injections have been made, at intervals of two or three days, cough and sputa disappear completely. Rapid improvement in the general condition takes place and dyspnœa and night-sweats cease. It is preferable to begin this line of treatment when destruction at the apices has first begun, but in desperate cases improvement may even be obtained afterwards.

The selection of the point for injection is dependent upon the changes present. Most often and best suited are the apices, fossa supraspinatus, or the second intercostal space; finally, the injection may be made into cavities present. The ordinary German hypodermic syringe holding gram. 1 is used, and is provided with a needle 6–8 cm. long. The injection is to take place slowly, and during this time deep respiratory movements are to be avoided, and the patient is to lie down for a few minutes after each injection. The pain is slight, hæmoptysis was not noticed at any time. No symptoms of poisoning were noticed after from twelve to eighteen injections. —*Centralblatt für klinische Medicin*, No. 50, 1888.

Von Ziemssen[1] on the Diagnosis of Tuberculosis.—In the diagnosis of phthisis the form of the thorax is important, and for determination of this the author advises the use of the cyrtometer. The flat paralytic thorax he considers suspicious, and advises the cyrtometer by means of which the outline of the chest is obtained. He also considers a diminution in the sterno-vertebral diameter of use in the diagnosis. Of especial importance is the determination of the height of the apices of the lungs, which in the healthy individual is equal on both sides. Flattening of one or both apices is noticed after regressive changes following larger or smaller infiltration at the apex. Spontaneous cure of apical trouble may occur; in the cicatricial tissue thus formed cavities often remain which in later life only give rise to symptoms, the patients dying of acute tuberculosis. The sputa of these patients, who are apparently in good health, always contain bacilli. Dulness at the apices is found, which after complete cure generally disappears, the cicatricial tissue becoming surrounded by emphysematous tissue. He advises, in tuberculosis of elderly people, especially when of distant organs, to carefully examine the apices as to their height and the amount of air contained in them, and in families where many cases of phthisis occur, and the parents are supposedly healthy, is this latter point insisted upon. Primary laryngeal tuberculosis will always be found on closer examination to be secondary. The presence of tubercle bacilli in the sputum is important, but the diagnosis is only to be made from all the symptoms taken together. In general a diminution in the number of bacilli in the sputum is of favorable prognostic import, and contrariwise, but there are many deviations from this rule. The presence of elastic fibres is important in the diagnosis. Bloody sputa is of grave import in beginning tuberculosis; of less, during healing. The presence of fever, spirometric determination of the capacity of the lungs, and the determination of the body-weight are mentioned; the latter point, according to the author, being too little used.

[1] *Klinische Vorträge*, ix. Leipsic, F. C. W. Vogel, 1888. Noticed in *Centralblatt für klinische Medicin*, No. 47, 1888.

MISCELLANY.

Toxic Effect and Gangrene from Cocaine.—Dr. F. Johnston, of Cairo, Ga., previous to operating for ingrowing toenail in a woman of 20, injected gr. ½ of cocaine into the soft parts on the inner side of the left great toe.

The operation was painless, uneventful, and lasted, from time of injection, thirty-five minutes. As the doctor was leaving, the patient became pulseless and collapsed with cyanosed lips. A drachm of ether hypodermically and two drops of amyl internally gave immediate relief.

The next day, on changing the dressings, it was found that the entire flesh on the inner side of the toe was gangrenous. Complete healing took place in two weeks. —*Med. News*, Aug. 25, 1888.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON THERAPEUTICS.

Gates (M. F.) on a Comparison of Antipyretics. — With a view of determining the relative value of antipyrin, acetanilid, phenacetine, and Niemeyer's pills as antipyretics, some experiments have recently been carried on at the Medico-Chirurgical Hospital.

The special point at issue was to determine which of these produced the most equable temperature.

Two patients suffering from hectic fever, due to chronic pneumonic phthisis, were selected, and to them the drugs were administered for varying periods, but under similar conditions. Their relative effectiveness seems to be best shown by comparing the average daily range of temperature during the administration of each.

For a period of four days one of the patients took nothing of an antipyretic nature, and had an average daily temperature range of 3.4° F., which may be considered as the probable range, if unmodified by treatment.

The following is a table showing the average range under the use of various agents, and the number of days each was given, arranged in the order of their effect.

	Medicament.	Daily Dose.	Average Range.	How Given.	No. of Days.
1.	Acetanilid.	20 grains.	.7833 +	Broken.	24
2.	Phenacetine.	6 to 12 grs.	1.1458 +	Broken.	15½
3.	Antipyrin.	15 grains.	1.4666 +	Broken.	3
4.	Phenacetine.	6 to 12 grs.	1.9443	Both ways.	35½
5.	Phenacetine.	10 to 12 grs.	2.1089 +	Single.	12½
6.	Creosote and Acetanilid.	5 gtt. & 5 grs.	2.1893 +	Broken.	21
7.	Niemeyer's pills.	Three.	2.7079 —	1. t. d.	24
8.	Acetanilid.	6 grains.	2.9844 +	Broken.	9½
9.	Nothing.		3.40		4
10.	Phenacetine.	7 grains.	3.5321 +	Broken.	7½
11.	Creosote.	3 to 15 gtt.	3.6503	Broken.	26½

From this we see that a uniform temperature was best maintained by acetanilid, in 5-grain doses four times a day; with phenacetine, 12 grains a day, given in divided doses second; and antipyrin, 15 grains a day third. Creosote, and small doses of phenacetine, gave ranges greater than when nothing was taken.

In the extreme range, from the highest to the lowest recorded temperature, the greatest—7.2 degrees—was noted while creosote was being administered, and the least—3.6 degrees—when antipyrin was used. However, acetanilid in large doses

gave, in one set of experiments, a maximum range of 4 degrees, and in another of 3 degrees, which is the lowest extreme range found in any single trial; but, in doses of 6 grains a day, it gave a range of 5.6 degrees, which sets it back, in the table, to fourth place.

Creosote alone gave a maximum range of 6.2 degrees, and an average range of 3.65, while its combination with a daily dose of 5 grains of acetanilid gave a maximum range of 5.2 degrees, and an average range of 2.18 degrees, a reduction of 2 degrees and 1.5 degrees respectively.

The experiment covered in all a period of 147½ days' time.

We have since tried phenacetine in two cases for a period of five days each, giving each patient gr. v. four times a day.

The average range was 1.78 degrees, the extreme range, 4.2 degrees, and the highest point reached, 101.6 degrees.—*Med. Times*, Jan. 1, 1889.

Davis (N. S., Jr.), on the Mode of Action and Value of Antipyrin in Typhoid Fever.—The author puts himself on record as saying that in his experience antipyrin is by no means a specific in typhoid fever, and that it is of little or no use, because of the antipyresis which it produces, and that it is of very limited use because of its other modes of action. It is not the fever, but the systemic poisoning, which is to be feared, and it is not impossible but that the drug intensifies the latter danger. The writer casts his vote in favor of hydrotherapy, a remedy which does not clog, but stimulates to action the emunctories through which the specific poison must pass.—*Med. Record*, Jan. 19, 1889.

A Warning against the New Antipyretic Pyrodin.[1]—Great caution is required in its administration, as it is apt to produce jaundice, followed by anæmia and even more serious symptoms due to hæmoglobin-æmia. Milder toxic symptoms have occasionally followed the administration of acetanilid or antifebrin, and also of phenacetin; but, as phenylhadrazin is a much more powerful poison than anilin, so also are the toxic properties of its acetyl compound much greater than those af acetanilid. In face of the poisonous qualities of pyrodin, we must warn the profession against the use of this drug generally. In exceptional cases, and where other antipyretics have failed, it may be useful, but great caution should be used. Small doses only (5 to 12 grains) should be given, and at sufficiently long intervals to enable one to watch any toxic effects, with the first appearances of which the drug should be stopped.—*Br. Med. Jour.*, Dec. 29, 1888.

Day (R. H.) on Salol in Typhoid Fever.—The author narrates what to him seemed a typical case of typhoid fever, which had been a week without treatment, and did not respond to calomel, quinine, or antifebrin, cured in five days by an emulsion containing salol 5 grs. and Dover's powder 2½ grs., every three hours, combined with 8 grs. of antifebrin at the same intervals until the fever was lessened. —*Jour. Amer. Med. Ass'n*, Jan. 19, 1889.

Gibson and Felkin on a Hitherto Unobserved Effect of the Salicylates.—Mydriasis and amblyopia are generally put down as possible symptoms of salicylic origin, but in a middle-aged woman with a phlegmonous erysipelas of the leg, *contraction* of the pupils, which did not react to light, tinnitus, deafness, occipital and parietal headache were noticed. Twenty grains of the salicylate of sodium were given every two hours. The contraction and immobility of the pupil appeared within eight hours of the commencement of the drug, and did not pass away until thirty hours after its last administration.—*Practitioner*, Jan., 1889.

Allison (W. R.) on a Case of Poisoning by Antifebrin; Recovery.—A man presented himself at my office about 3 P.M. on August 14th, informing me that he had taken some horse medicine, and upon examining my patient I found the most cyanotic subject that I ever had the misfortune of treating, showing a livid tint of the skin, resembling the tint of asphyxia, and complaining of general weakness, pain near the heart, a soreness beneath the sternum, with a beating pain passing from temple to temple, while to assume the erect position caused giddiness, increasing the cyanotic hue and a stinging pain in the eyes, while to assume the recumbent position gave him freedom from all suffering. Patient had no nausea or vomiting, but body was bathed in perspiration, respiring thirty times per minute, and a pulse of 110.

The medicine was taken about 5 A.M., producing in thirty minutes a form of intoxication and desire to sleep, which our

[1] See MEDICAL ANALECTIC, 1888, p. 536.

patient indulged in until 10 o'clock. Gave him stimulants and ordered him to keep a recumbent position. I was afterwards informed that he had taken of a mixture of antifebrin one ounce, and elixir taraxacum comp. six ounces, of which solution he drank about seventeen drachms. I am sorry to say I did not take his temperature. The patient, a farmer, resumed work the next day. Sexton tells of a case where 10 grains of antifebrin reduced the temperature from 105° to 102° F.; 5 grains more were given, which were followed in two hours by cyanosis of the whole body, profuse sweating, and collapse; while Pavai Vajna states that in weak patients a dose of 4 grains may produce collapse, while in some cases 15 grains has no effect at all.—*Jour. Amer. Med. Ass'n*, Jan. 19, 1889.

Cushing (W. R.) on the Influence of Antifebrin on the Secretion of Milk.—I used antifebrin at irregular intervals, in the case of a lady with mild typhoid fever, with a view of controlling the temperature. The dose was five grains two or three times in twenty-four hours. At the time she was nursing a child, between five and six months of age. As the fever developed, the secretion of milk developed very much, but I found after the administration of each dose of antifebrin, when its effect began to show itself on the temperature, that there was a sudden accumulation of milk in both breasts, to such an extent as frequently to demand relief by mechanical means. I do not regard this as a direct effect on the mammary gland, but supposed it to have been indirect by lessening the fever and by promoting secretion generally as a result, as a sweat would occur at the same time. Recollection of this fact may, however, be of service in other cases.

Reasoning from analogy (provided the explanation of its action given above is correct), we have good cause to think it would be especially indicated in so-called milk-fever, with high temperature and delayed establishment of the mammary secretion.—*Med. News*, Dec. 22, 1888.

Poisoning by Acetanilid.—A case is reported from Berlin of poisoning by acetanilid, or as it is sometimes called antifebrin. A man, thirty-eight years of age, bookbinder, and subject to bronchial catarrh, went to a druggist suffering from an attack of hemicrania. The latter gave him two doses of the drug of two grains each, which the patient took with an interval of twenty-four hours. The first dose was well borne. A quarter of an hour after the ingestion of the second dose marked symptoms of poisoning appeared; cold sweats, a feeling of extreme prostration, intense malaise, cardiac palpitation, small and accelerated pulse, with a general cyanotic tint spreading over the face, lips, and hands. The patient was given a cup of black coffee, followed with castor oil. Applications of mustard were also made, and the cyanosis gradually disappeared. The other toxic symptoms vanished, but slowly, and for some days the patient felt much depressed.—*Med. Press*, Jan. 2, 1889.

Thomas (T. P.) on the External Application of Nitrate of Silver in Erysipelas.—The author calls attention to this by no means new therapeuric procedure, the efficacy of which has been recently tested, and concludes that it is not advisable to employ it freely where there are any blisters, or where there may be any crushing. If possible it ought to be employed before that stage. The best and proper strength will be found to be gr. 20 arg. nit. to each ʒ i. of sp. ether. nit. If called to a case he generally runs a little cotton-wool gently over the surface of the skin, so as to remove any secretions that may be lying thereon. After pouring a little of the remedy into a wineglass, and having charged the camel-hair brush with some of it, he then gives the affected parts a good coating by running the brush once or twice over the skin. In a short time the parts so painted will get brown and eventually quite dark. A fine uniform covering will be formed, and will be found much better than cotton-wool, etc., as a protection from the air.

With iron internally and this application externally, it is often marvellous how quickly the patient will get better. There is a grateful cooling feeling at the time of painting, and the burning sensation present in erysipelas (if nothing be done) is generally removed.—*Provinc. Med. Jour.*, Jan. 1, 1889.

Smith (W. J.) on the Chemico-Physiology of Sulphonal.—In the *Practitioner*, Jan. 1889, the author has studied the action of the drug on the activity of tissue changes, and the changes of the drug during its passage through the organism.

The amount of nitrogen and sulphuric acid in the urine is not increased by giving the drug while the flow of urine is augmented.

Sulphonal in moderate doses is completely changed during its passage through the body into a sulphurated organic substance, such change being the more remarkable because sulphonal is extremely stable, and because some allied bodies, *e.g.* ethylene-diethylsulphon $\left(\begin{array}{l} CH_2\text{-}SO_2\text{-}C_2H_5 \\ | \\ CH_2\text{-}SO_2\text{-}C_2H_5 \end{array}\right)$, pass into the urine unaltered.

The elimination of sulphuric acid is not increased by taking sulphonal, showing that the substance formed from it must possess considerable stability.

Sulphonal in moderate doses does not affect the metabolism of the nitrogenous tissues. The author has given to a dog, dissolved in its food, 3 grammes of sulphonal daily for five weeks, and has found that the appetite and general health of the animal have not suffered in consequence, though after such large and long-continued doses a small amount of unaltered sulphonal can be detected in the urine.

Amberson (J. B.) on the Effect of Petroleum on the Human Body.—Within the last ten days I had an obstinate case of false croup. Along with remedies prescribed by me one night when bad, the child was given kerosene. He was better next morning, continued to convalesce and is now well. During my college days, in western Pennsylvania, I had a near relative who was sorely afflicted with asthma. His remedy for the attack was a teaspoonful of kerosene taken early. A few years ago a lady of Baltimore told of a friend who had been very much emaciated, and supposed to be in the later stages of consumption, but who was then in robust health and quite fleshy, apparently restored by the use of crude petroleum. As a rubefacient, it is in common use here by the laity, is very efficient, and produces very decided effects if confined. That it is not toxic, in pretty fair doses, is seen by the following: An elderly gentleman going to take an evening dram at home in the dark, mistook his kerosene jug for the whiskey jug, put it to his mouth and swallowed a fair allowance before he discovered his mistake. He hurried to my office to know what to do. His face was somewhat flushed and the pulse full and frequent, mostly, I thought, from his alarm. I gave him nothing but assurance, and no ill effects followed.—*Med. Times*, Jan. 15, 1889.

M'Call (R. B.) on Rectal Medication in Intestinal-Tract Lesion.—In the *Medical Standard*, January, 1889, the author very pertinently points out the harm that may accrue from common methods of treating intestinal obstruction and fecal impaction. His remarks of course apply particularly to obstructions of the lower gut, where fecal obstruction is most common.

He criticises, and justly, the common practice of giving purgatives, when the obstruction is low down, for two very good reasons: first, because of the doubtful utility of such a method; and secondly, because of the unnecessary irritation and wear and tear the administration by the mouth of active purges entails upon the stomach and upper intestinal tract. He advocates the more frequent use of enemata and rectal medication in such cases, and then, the impaction being relieved, unirritating and simple remedies will suffice.

Zeisler (G.) on a New Method of Treating Gonorrhœa.—The author advocates treating gonorrhœa by the introduction of dry powders into the male urethra, by means of a canula, through which the powder is forced by a hollow spiral. The patient evacuates the bladder, and the urethra is disinfected by a 1 to 10,000 permanganate or some other suitable alkaline solution. The urethra is dried by gently stripping the penis with a clean towel. The instrument is then inserted and the powder introduced as the instrument is withdrawn, and in this way the whole urethra is filled with the powder.

In the beginning the mildest possible powders should be used. A good one is: Calomel, 1 part; bismuth subcarbonate, 2 parts; and boric acid, 12 parts. Later it can be made more astringent by the proper addition of alum, subnitrate of bismuth, and hydrastine.—*Med. Record*, Jan. 19, 1889.

Sellwood (J. J.) on Sea-Sickness and its Relief.—After experimenting with 20 mild and severe cases, the author recommends the hydrochlorate of cocaine as of great value. He gives ¼ gr. every hour until emesis is relieved. The dose should then be diminished by one half for

12 hours, and gradually decreased from that on until the patient is able to take and retain nourishment.—*Therap. Gazette*, Jan. 15, 1889.

McReddie (G. D.) on Cocaine in the Treatment of Ulcers.—For the relief of pain caused by the dressing of burns, fistulæ, painful ulcers, etc., I use a 2-per-cent. solution, and have it sprayed upon the surface as it is exposed. This acts almost at once, and the dressing may then be continued with very little pain, and, in the case of extensive burns, with much less shock. The solution should in such cases be used warm. In the case of fistulæ a few drops should be poured over the sinuses before they are packed. With a 2-per-cent. solution there is little fear of constitutional effects, and it will be found to act as well and as quickly as a much stronger one.—*Br. Med. Jour.*, Jan. 5, 1889.

Webster (D.) on a Case in which Croton Oil was Accidentally Applied to the Eyes.—After referring to cases where a ten-grain solution of nitrate of silver was used in a case of iritis instead of atropia, and where a homatropine solution was discovered to be a poor substitute for cocaine, he relates the case of a man who freely applied, instead of an eye-salve, croton-oil liniment to the edges of his lids. When seen his eyelids were red and swollen, his eyeballs bloodshot and watery, and there was considerable loss of corneal epithelium. He suffered much from smarting, burning, and photophobia. He made a rapid recovery under the use of a solution of sulphate of atropia in castor oil, four grains to the ounce.—*Med. Register*, Jan. 12, 1889.

Pedigo (L. G.) on the Antagonism between Amyl Nitrite and Prussic Acid.—The author's experiments consisted in administering prussic acid in large doses, hypodermically, and beginning the use of the antidote at once by inhalation. Collateral experiments were performed in which the poison was given in equal or smaller doses, and the antidote withheld. The effects were observed and compared, always showing a remarkably heavy balance in favor of the remedy. In one of these experiments a dog's life was saved by the use of the nitrite of amyl from the action of the same dose which had just killed a similar dog in five minutes and fifteen seconds without treatment. In commenting on the experiments, a theory was evolved to explain the action and antagonism of the two drugs. The convulsions and arterial spasm of prussic-acid poisoning were attributed to paralysis of inhibitory nerve centres. The relief of these symptoms by nitrite of amyl was accounted for on the supposition that this drug stimulated those centres. The two drugs were shown to antagonize each other in six distinct physiological items, thus proving the amyl to be a more nearly perfect physiological antidote to prussic acid than was known for any other poison. He suggested the use of the same remedy in cases of poisoning by other cardiac depressants, and enumerated aconite, veratrum viride, and gelsemium.—*N. Y. Med. Jour.*, Nov. 24, 1888.

OCCASIONAL REPORT ON OBSTETRICS.

BY ELIZABETH STOW BROWN, M.D.

McKee on the Diagnosis of Pregnancy by External Resources.—The author makes a plea for the external diagnosis of the pregnant state, in which he regrets that our country is behind the European practice in this respect. It is in the immense hospitals of Dublin, Germany, and of France, where this art of diagnosis of pregnancy by external means is best taught and practised. "He who does not examine a woman does not infect her," is a maxim of Crédé. In his recent work this authority teaches that woman in labor, and in the lying-in-state, is diseased only through infection from fresh wounds. From the most careful digital examination there may occur some wounds, and therefore examinations should be limited to the fewest number possible, or dispensed with altogether. The digital examination is omitted altogether for weeks in the lying-in-hospital in Leipsic, especially if the health of those confined is not of the best. The author teaches that in labor the external examination should be given precedence, and the internal employed only when demanded by the conditions of the case. But to do this intelligently, all the external means of diagnosis must be wisely and scientifically employed.

Inspection shows pigmentation of the face; the pigmented areola or the tubercles

of Montgomery of the breasts; the size of the abdomen and the brown line extending down the centre; the state of the umbilical cicatrix; a transverse furrow, when the ring of Bandl has contracted; the striæ on the abdomen; movements of the abdominal wall from activity of the fœtus; and height of uterus.

Palpation proves the presence of the fœtus *in utero* and the number of fœtuses; the presentation, position, approximate size, general conditions of the fœtus and the relations of the uterus. After carefully exploring and outlining the uterus, alternating pressure can produce ballottement by displacing the solid body. The poles and parts of the fœtus may be made out. If the abdominal walls are thick, and the amniotic fluid abundant, and it is difficult to decide the points of diagnosis, it is recommended to seize the fundus of the uterus in the hand, and force it down against the symphysis pubis, and thus bring the back more in the range of palpation. Abdominal ballottement may be made with one or both hands. It is one of the most reliable signs of pregnancy. This has been described as the sensation of ice floating in a vessel of water and striking against the sides. The placenta can sometimes be detected by palpation when it is placed anteriorly. It is to be recognized as a fleshy mass which raises the palpating fingers from the fœtal surface. The death of the fœtus can often, though not always, be determined by palpation. By means of the calipers the fœtus may be measured. Applying them to the head and breech gives one half the length of the fœtus, its age consequently, and the size of the uterus. The cord has been made out passing over the back. Intermittent uterine contractions, first brought to notice by Braxton Hicks, the author considers almost infallibly peculiar to the pregnant uterus. The contractions are constant and are not simulated by any other sign. Fœtal movements may be sensible or visible. Extra-uterine fœtation can be detected only when a distinct lateral tumor is palpable, quite distinct from the uterus. Palpation ought to be practised after auscultation, because manipulation disturbs both mother and child, increases the heart beat, and seriously modifies the auscultatory signs.

Percussion is of the least value of the means of external diagnosis. The amount of distension of the bladder is the most important of the things learned. The claim that pregnancy can be made out in the second month by percussion, the writer holds to be unfounded.

Auscultation is one of the most important methods of external diagnosis, but is often relied upon too much. The author in most cases prefers the unaided ear to the stethoscope. Auscultation enables the examiner to hear the umbilical or funic murmur, the placental murmur, the pulsations of the abdominal aorta, and the gurgling noises caused by the fluids and air in the intestines. Occasionally there may be heard a splashing noise due to the movements of the fœtus in the liquor amnii, the fœtal shock, muscular susurrus, sounds due to the friction of the uterus against the abdominal walls, to the impact of the fœtal limbs against the uterine walls; and, the most important of all, the fœtal heart. The auscultator is warned not to listen with the head lower than the body, for he thus causes an increase of the cerebral circulation and hears imperfectly.—*Pittsburgh Med. Rev.*, Dec., 1888.

Atthill (Lombe) on the Action of Certain Drugs on the Utero-Ovarian System.—After considering certain drugs that are applicable to amenorrhœa and menorrhœa, the author deals at some length with the action of ergot. He points out that it is very doubtful if ergot ever originates clonic contractions of the uterus during pregnancy, unless the organ is prepared from some pre-existing cause to expel its contents. The writer, when in midwifery practice, was in the habit of frequently prescribing ergot as a preventive to post-partum hemorrhage, commencing its administration a week or ten days before the expected advent of labor. He never once had occasion to suppose that it hastened that event, but, on the contrary, in several cases the period of utero-gestation seemed to be lengthened. In cases of threatened abortion he has seen the hemorrhage checked and pregnancy proceed normally under the administration of ergot. It seemed, indeed, to the writer to "act as a uterine tonic." In other cases, and perhaps the majority, it seemed to produce no effect at all; in a few it induced clonic spasms, but in these there was always reason to think that the ovum was already blighted.—*Dublin Jour. of Med. Sci.*, Dec. 1, 1888.

Bacteriology of the Lochial Discharge.—Dr. D. von Ott, in a recent paper, reports his bacteriological examination of the lochia of ten women. He has obtained the same results as Doedulein, that from healthy puerperæ the uterine secretions contain no micro-organisms, and are harmless to other lying-in women. The other secretions of the vagina were examined, and it was discovered that in those parts where air was excluded fungi could not be found. The author also believes that, whereas micro-organisms are found in the vagina outside of the lying-in period, the act of parturition cleanses the vagina of germs.—*Arch. für Gyn.*, xxxii., 3, p. 436, 1888.

Vomiting of Pregnancy.—Jaffé considers the treatment of this frequent and distressing disorder either expectant or operative. In the first stage he advises quiet, the recumbent posture, and fluid food. If all food is vomited, he advises peptonized preparations by the rectum. Of drugs, the author believes the bromides of potassium and the opiates the most effective. Any local abnormalities are, of course, to be removed if possible. In intractable cases, the production of abortion is the only cure. In the second stage, the interruption of the pregnancy is surely indicated. The author claims that statistics do not show a distinction between light and severe cases.—*Volkmann's Samml. klin. Vort.*, No. 305, 1888.

Grailey Hewett believes displacements of the uterus to be the cause of the severe vomiting of pregnancy. He reports over 50 cases in which pronounced displacements of the uterus existed, causing severe vomiting of pregnancy. In 11 cases the uterus was retroverted and impacted; in 30 anteflexed (in 17 of these impaction was present); in 12, the uterus was anteflexed with indurated cervix; and in 6 it was fixed in the pelvis. When these displacements were corrected cure followed; 11 patients aborted, and 3 died.—*Med. Press*, p. 409, 1888.

Scarlatina during Pregnancy and in the Puerperal State.—Dr. Robert Boxall has made an elaborate study of scarlatina as a complication of obstetric conditions. He presents records of 16 cases and gives a review of the literature of the subject. The author carefully differentiates the true scarlet-fever infection from a septic fever with scarlatinoid eruption. The writer states at the outset that:

"Infection by the poison of scarlet-fever, either during pregnancy, during labor, or during the lying-in period, is followed in the puerpera—

"1. By scarlatina, presenting, for the most part, the usual symptoms, and running the ordinary course of the disease.

"2. By scarlatina, presenting, for the most part, the usual symptoms, and running the ordinary course of the disease, but associated with local and general lesions, *e. g.*, metritis, cellulitis, peritonitis, pyæmia, such as are produced by ordinary septic poison.

"3. By scarlatina in which all the usual symptoms of the disease are absent, but in which local and general lesions, such as are produced by ordinary septic poison, are present; in a word, infection by the poison of scarlet-fever is followed by a disease clinically indistinguishable from puerperal septicæmia, or from puerperal fever (as above defined)."

He infers from the analysis of his cases that scarlatina almost invariably appears within the first week of the puerperium, and that its occurrence later is rare. Exceptionally, scarlatina may show itself during pregnancy, but if the infection so occur, labor may be thereby precipitated. When infection takes place during or shortly after labor, the incubation period may be shortened. The author finds that during pregnancy the throat symptoms are unmodified, but that after delivery angina is rare. If labor occurs during the incubation period of scarlatina it runs for the most part its usual course; if inertia occurs, it sets in late in the labor. A peculiar and almost characteristic odor has been noticed. When labor occurs during an attack of scarlatina, the pains are apt to be feeble, inertia comes on early, and post-partum hemorrhage is liable to occur. The same peculiar odor has been noticed. Dr. Boxall thinks that the subsequent involution of the uterus is not much, if any, retarded; that if antiseptic precautions are observed, lacerations heal well, and the lochia do not become offensive; that the peculiar odor may be observed; that the lochia proceed naturally; that the mammary secretion is frequently diminished or arrested; that when scarlatina appears during pregnancy the fœtus may or may not be affected *in utero*.—*Trans. Obst. Soc. of London*, 1888.

Grandin on the Treatment of Puerperal Endometritis by Means of the Curette.—Dr. Egbert H. Grandin urges the use of the dull curette in septic endometritis to clear the uterus of all particles which are undergoing decomposition, whether partially loose, partially adherent to the superficies, or extending to the muscularis. The author believed that the majority of accoucheurs, the world over, clung to the intra-uterine douche. Some objections to this method were that the douche had frequently to be repeated for days, and might then prove inefficient; that the antiseptic agent might prove toxic; that there might be reintroduction of septic matter. The use of corrosive sublimate had been forbidden in some European maternities because of its danger. Dr. Grandin has not introduced a bichloride of mercury solution into the uterus for two years. In the author's opinion the dull curette would often replace the douche, and at the same time answer all the indications. The dull curette was harmless when used with care. The practitioner should be as skilful in its use as with forceps or the irrigation tube. As soon as fetor of the lochia appeared, it was necessary to carefully differentiate its source. If it were from the vagina, a douche with boiled water or an antiseptic solution would cause the fetor to disappear. If after a few hours it reappeared, the author would administer an intra-uterine douche. If the fetor again returned, he instituted active treatment. He would place the patient in Sims' position, insert the speculum, fix the cervix with the tenaculum, introduce the curette bent to the correct angle, thoroughly scrape the interior of the uterus, and finally give another douche. Frequently the patient would undergo an astonishing change in twenty-four hours. The author emphasizes the fact that the puerperal state renders the use of the curette particularly safe and easy. The cervical canal is open, and the instrument finds its own way, as it were, into the uterus. Still the timid practitioner might continue to use the Doléris brush. The disturbance of the patient was little greater than during the use of the douche.—*Med. Record*, Jan. 12, 1889.

Hart on an Improved Method of Managing the Third Stage of Labor.—The "improved method" is based on a new view as to the separation of the placenta. The author holds that all separations of placenta or membranes follow one mechanism; that they separate when there is a disproportion at the plane of separation between their area and their site of attachment. This disproportion is only slight, as the trabeculæ are microscopic. The placenta, in short, separates in the third stage after the pains, and is expelled, when separated, by the pains. The important practical point which the writer urges is that manipulation cannot separate the placenta, but can only aid expulsion. He deprecates Crédé's method for separation of the placenta, denouncing it as the most dangerous plan possible. He merely keeps his hand on the uterus, employing manipulation of it if bleeding comes on, and limiting the Crédé method to helping the expulsion. His guide to the period of separation was the marked decrease in the size of the uterus. His reasons for the treatment are: ergotism and manipulation are used to insure good marked retraction and to empty the intervillous spaces well. The fœtal circulation is aspirated thoroughly by allowing the child to cry well, and by draining the cord. These two measures give the necessary disproportion sooner, as the placenta cannot now follow up the increase in placental area during relaxation, and thus sooner the trabeculæ are torn apart.—*Edin. Med. Jour.*, Oct., 1888.

MEDICINE AND PATHOLOGY.

Hesse (J.) on the Treatment of Diabetic Coma.—The author reports a case of diabetic coma treated first by intravenous transfusion with subsequent subcutaneous injection of a solution of carbonate of soda, the line of treatment being based on the theory of Stadelmann that the cause of diabetic coma is an acid intoxication of the body. The case was one of deep coma, and 250 ccm. of a 4-per-cent. sodium carbonate solution were injected into the right basilic vein with the effect that six hours after the patient became perfectly conscious. The next day returning somnolence was removed by the subcutaneous injection of 200 cc. of sodium carbonate solution; a day and a half after coma returned again, but before transfusion could be again accomplished the patient died. The author recommends

this treatment to further trial.—*Berlin klin. Wochenschrift*, No. 19, 1888.

W. V.

Sweet (A. B.) on Diabetes Mellitus Following Obstructive Jaundice.—A man of fifty-nine was attacked with obstructive jaundice in October, 1887. There were acute pain, enlargement of the liver and gall-bladder, an intolerable itching, with jaundice and obstinate constipation, finally overcome by large doses of salines and repeated 5-gr. doses of calomel with jalap. This attack lasted 12–14 days, when a relapse, lasting 8–10 days, took place. Convalescence was slow, and in four or five weeks polyuria was noticed. Eight weeks later he was passing from ½–¾ gal. urine, which had a sp. gr. of 1040, and contained from 2–3 per cent. of sugar. He lost 60 lbs. of flesh in 3½ months.

The treatment was mostly dietetic. Saccharine in small quantities was allowed in the coffee. Codeine, in increasing doses, and antilithic remedies were employed. Complete recovery took place in a few months.—*N. Y. Med. Jour.*, Jan. 19, 1889.

Herringham (W. P.) on Eighty Cases of Chorea; Antecedents, Family History, State of the Heart, and Subsequent History.—Acute rheumatism preceded the attack in nineteen cases, immediately in four, at some interval in fifteen. It accompanied the chorea in two cases. Pains in the joints preceded the attack in fifteen cases, accompanied it in one case. The total number of cases in which rheumatism could be traced was thirty-seven. Injury, shock, or violent burst of emotion preceded the attack in six cases. The interval was never greater than two days. Hard mental work or worry was found in twenty cases. These influences were not mutually exclusive, since all those classed under injury, shock, or emotion could alone be considered as exciting, the others only predisposing, causes. In twenty-five cases none of them could be traced, and of these fourteen were first attacks. Nearly all the patients were delicate; headaches and indigestion were the most common complaints. Family history (calculated from parents, brothers, and sisters only): Rheumatic fever had occurred in twenty-five out of seventy-five families, seventeen of which belonged to thirty-four patients of the rheumatic classes, and the remaining eight to forty-one in whom there was no history of rheumatism. Chorea had occurred in twelve families, nine of which were also rheumatic. State of the heart (throughout): Natural in ten, uncertain (that is, doubtful) endocarditis in twenty-five, certainly diseased in twenty. Signs of disease developed during observation in eleven cases, and signs which were at first present vanished during observation in four. Thirty-seven cases were seen again, usually at an interval of two years or over. For the most part they presented the same state as before. Of the twenty-five doubtful cases two had become healthy, seven appeared certainly diseased. Of the eleven cases which developed signs during the attack of chorea, five were re-examined, and of these two were natural, while three gave good evidence of disease. This last was important, as tending to show direct influence of chorea upon the heart. The following conclusions were drawn: 1, that a large number of choreic patients were liable to rheumatism; 2, that choreic patients were nearly always of a delicate constitution; 3, that chorea was sometimes directly caused by emotion; 4, that chorea might cause permanent heart disease; 5, that it also gave rise to signs of heart disease which were not permanent.—*Br. Med. Jour.*, Jan. 12, 1889.

Garrod (A. E.) on the Relation of Chorea to Rheumatism, with Observations of Eighty Cases of Chorea.—Sixty-one of the patients were females, and only nineteen males. Forty-nine were suffering from first attacks. The average age of the female patients was considerably higher than that of the males. There was a history of rheumatic fever in the near relations of twenty-six patients, of rheumatism with swollen joints in those of three, and of rheumatism in three more, making a total of thirty-two, or 40 per cent., with rheumatic family histories. It was pointed out that the tendency to chorea was far more marked in some rheumatic families than in others, and examples were quoted illustrating this point. The total number of cases in which there was a personal history of rheumatic manifestations other than endocarditis was thirty-six, or 45 per cent. In fifteen of these there was a definite personal history of rheumatic fever, in nine of rheumatism with swollen joints, in one of joint pains confining the patient to bed, and in nine of joint pains only. One patient had nodules but no arthritis, and one had acute pericardi-

tis. It was shown that the same patient sometimes had an attack of chorea with joint pains only, and a later attack with well-marked rheumatic fever. Evidence was brought forward to show that some cases in which there was no family history of rheumatism, and no personal history of joint pains were nevertheless of rheumatic origin, cases being quoted of rheumatic patients who had previously suffered from chorea, of the development of erythema nodosum and arthritis in the course of apparently non-rheumatic chorea, of chorea with endocarditis and nodules without joint pains, and of the association of acute pericarditis with chorea. In fifteen cases the onset was ascribed to fright, but in some instances inquiry showed that the fright followed the onset of the chorea. A definite murmur was heard in forty-five cases, or 56.25 per cent., and in six others the first sound was murmurish. The percentage of murmurs was naturally highest amongst those with personal histories of rheumatism, but was lowest amongst those with family history only. In some instances the murmurs developed under observation. The opinion was expressed that the endocarditis of chorea was probably always of rheumatic origin, but that we had no evidence to show that all chorea was of rheumatic origin, a considerable number of cases being probably due to emotional and other causes.—*Br. Med. Jour.*, Jan. 12, 1889.

Shaw-Mackenzie (J. A.) on Tape-Worm in an Infant on Raw-Meat Diet.—A. B., aged one year and seven months, was the third child of healthy parents; it was weaned at nine months, and fed on milk and broth, etc. It was a well-developed child, but always suffered from constipation. In May last, at twelve months old, after a severe attack of bronchitis and laryngitis, raw-meat diet was begun, an ounce to an ounce and a half of finely scraped and pounded beef being given on alternate days. The child improved greatly, but in October began to fall off in looks; and on the 21st joints of tape-worm were noticed in the motions. Two fifteen-drop doses of liquid extract of male fern brought away several feet of the worm, but though several small proglottides were noticed, no head was found, and though a repeated dosing was gone through a fortnight later, nothing has been noticed since.—*Br. Med. Jour.*, Jan. 5, 1889.

Greene (G. E. J.) on Ascares Lumbricoides in Infants Fed Solely at the Breast; a Probable Cause.—I have from time to time seen round worms passed by babies whose *only* nourishment was partaken of at the breast, and have been puzzled to account for their entrance into the infantile organism. The only plausible explanation seems to be as follows. Some of the ova with which the anal orifice is so liberally supplied in children suffering from "ascaris" are, taking into consideration the strong tendency to scratch that region in this disease, lodged under the nails and transmitted from thence to the baby's mouth, a not improbable "manière de voyager," having regard to the frequency with which the younger members of a family consign the finger to be assiduously suckled by their restive charge. I wish to record the following observations in support of the foregoing explanation. 1st. I have never seen instances of infants at the breast affected with *round worm* when there were not young children in the same house, or, not being in the house, they were not in the habit of running in "to nurse baby." 2d. In every case I have been able to prove the existence of "ascares lumbricoides" in one or other of the youthful nurses.—*Med. Press*, Dec. 12, 1888.

MISCELLANY.

Neale (J. H.) on Hypertrophied Hymen; Congenital Absence of Uterus and Appendages.—More than a year ago a girl, aged twenty-four, was brought to my out-patient room at the infirmary by her mother, who stated, with great candor, that her daughter had recently been discharged from her situation as housekeeper to a farmer in the country; and as she "had not seen any thing," she was anxious to know "if there was any thing the matter." I formed my own conclusions as to the purport of the inquiry, and first examined the breasts, the condition of which negatived the presumption of pregnancy.

Further questioning elicited the fact that the girl never had menstruated, so, with the mother's consent, I made a vaginal examination. The exploring finger encountered a thick fleshy diaphragm, which completely occluded the vaginal orifice. I found, however, that this membrane could be easily

pushed in front of two fingers, as far as the latter could reach.

I thoroughly examined the membrane by drawing it outwards with a pair of forceps.

About the centre was a reddish, umbilicated prominence, pointing to the existence of a possible small opening; but with the aid of the finest probe no such opening could be detected.

By bimanual examination, I found that the inside and outside fingers met behind and above the bladder (which had been previously emptied) with nothing between them but the membrane in question and the anterior abdominal wall. Had the probe been roughly used, or a sharper instrument employed, it would undoubtedly have entered the peritoneal cavity.

I explained the defective anatomical condition to the mother, adding the advice that if ever her daughter were sought in marriage, the fact ought not to be concealed that she could never bear children. The explanation was apparently so satisfactory that neither mother nor daughter ever again appeared.—*Br. Med. Jour.*, Jan. 12, 1889.

Ormsby (L. H.) on Operations for the Radical Cure of Varicose Veins.—The author first calls attention to the various methods that have been adopted for the radical cure of varicose veins, viz.: 1. The injection of the liquor perchloride or persulphate of iron, or a strong solution of tannic acid into the vein for the purpose of causing coagulation of the blood. 2. Tying the vein in different points along its course. 3. Cutting out portions of the vein. 4. The application of caustics. 5. Tying of vein at different points, and dividing it subcutaneously between the ligatures. He feels, however, that the best procedure, and that attended with the least danger to the patient, is the method by acupressure, taking care when passing the pins to see that they pass directly behind the vein, not through it or in front. The length of time to allow the pins to remain depends considerably on the case, the size of veins, and the situation affected. From three weeks to a month is the usual time he allows them to remain in.—*Med. Press*, July 4, 1888.

Fatal Result of a "Snap" Diagnosis.—The *Am. Practitioner and News*, Dec. 22, 1888, relates the fatal results which followed a hasty operation performed by one man on the strength of another's diagnosis. "Dr. X. accompanied me as my assistant to do an operation of some kind upon the rectum. We did that operation, and Dr. Y. remarked that, on our way home, he would like us to see another case with him, and he brought us to see an old negro. Before we examined the case the doctor said: 'This is a case of abscess that I want one of you to open for me. I have been visiting this man for some time, and think he is about ready.' This abscess was in the popliteal space. The room was very dark, and we had no light beyond what was given us by one bad oil lamp. Without tracing any history, without giving it any minute examination, but going on the diagnosis of Dr. Y., Dr. X. opened one of my knives, plunged it into the supposed abscess, and, to our surprise, the blood spurted out. All we could do then was to cut down in Scarpa's triangle and tie the femoral artery. The man died on the third day." Such carelessness seems almost incredible.

Douglass (H. B.) on Pepsin in Surgery.—The employment of pepsin in surgery was suggested to the author by the recent local use of some digestive ferments in diphtheria.

For some months he has used it in all ulcerations covered with a slough or having a membranous base. The pepsin digests this slough and brings about a healthy condition. The action of the pepsin ceases when the slough has dissolved. In cicatricial tissue causing anchylosis, pepsin is of use by dissolving the cellular element.

He employs pepsin in scales or combined with lanolin (1–5).—*Med. Record*, Dec. 22, 1888.

Richardson (B. W.) on the Absolute Signs of Death.—The signs of death enumerated by the author of the paper are as follows:

1. Respiratory failure, including absence of thoracic movement, respiratory murmur, watery vapor from the mouth, etc.
2. Cardiac failure—absence of heart beat and sounds, absence of pulse, absence of venous turgescence on applying a ligature.
3. Fall of temperature.
4. Muscular collapse and rigor mortis.
5. Absence of pink coloration of tissues.
6. Advent of putrefactive changes.
7. Absence of red color as seen by transmitted light through transparent tissues.
8. Absence of muscular contraction to galvanism.

9. Absence of reaction when ammonia is injected hypodermically.

10. The needle test.

He pointed out that no individual sign was absolutely reliable, and quoted numerous interesting anecdotes in illustration of the exceptions that are met with.—*Med. Press*, Dec. 12, 1888.

Klein (W. F.) on Death from Impaction of Food in Larynx, Due to Paralysis Following Diphtheria.—On July 3, 1888, I found a child of eight suffering with a severe attack of pharyngeal and nasal diphtheria. The pharyngeal surface, as well as that of the palate, was covered with a very thick membrane, and the nasal passages were almost entirely occluded.

At my seventh visit, I found that the child had entirely recovered, with the exception of a slight discharge from the nose. She was without fever, or any other constitutional symptom whatever. It was, however, almost impossible for her to swallow any liquid. I immediately put my little patient on small doses of sulphate of strychnine, and cautioned the mother not to allow her to take any solid food, and to keep her in the recumbent position. The following day I was shocked to hear that the child had died. I suspected heart failure, but, on inquiry, I learned that the child had been allowed to go to the family table and partake of solid food, and, in the act of deglutition, a piece of bread became lodged in the larynx, and death occurred from strangulation before medical aid could be summoned.—*Polyclinic*, Dec., 1888.

Andrews (E.) on the Success of Repeated Operations Upon the Same Nerve in Facial Neuralgia.—Where the lesion is accessible and peripheral, the first operation often cures. In those cases where the disease has reached the semilunar ganglion or its neighborhood, and where for any reason entire extirpation of the diseased tissue is impossible, the author thinks that still stretching, avulsion, or excision of a piece acts mechanically to some extent upon the substance of the ganglion itself, bringing immense relief, and sometimes permanent cure to the patient. In this way, cutting off the irritating external impressions from reaching the diseased part, a prolonged "physiological rest," which favors recovery, is obtained. When the seat of irritation is between the ganglion and pons, or even in the central nervous system, an operation may still succeed by cutting off external impressions as mentioned before. One ought, then, never to give up a case of this kind until all accessible parts of the nerve are removed.—*Jour. Am. Med. Ass'n*, Jan. 19, 1889.

Burchmore (J. H.) on a New Surgical Dressing.—Take an ordinary test-tube, of suitable size, and by running the finger well into it one will have the dressing in its rudimentary form. It consists simply in covering the injured part, whatever it may be, hand, arm, leg, or foot, with a sort of glass jar, or, in the case of some of the flat or irregular parts, with a flanged glass box. By packing the ends with some air-tight material, such as cotton, rubber, adhesive plaster, etc., the suppurating lesion, in the case of open wounds, is where it can be easily seen and irrigated when necessary, with no danger of external infection.

In the case of a closed wound, no disturbance of the dressing need take place till the wound is healed.

In the case of a finger wound the glass tube is placed in some antiseptic solution, and then, after cleansing, the finger is run in, the space about the finger and the edge of the tube is packed with borated cotton. Over this, embracing part of the finger, is wrapped an air-tight dressing.

In the case of an open suppurating wound, openings may be made for the introduction and escape of irrigating fluids.—*Med. Standard*, Jan., 1889.

BOOK NOTICE.

Favorite Prescriptions of Distinguished Practitioners with Notes on Treatment.—By B. W. PALMER, A.M., M.D. New York, E. B. Treat, 1888.

This is a judicious compilation of standard prescriptions gathered from the published writings or unpublished records of such able physicians and authors as Drs. Fordyce Barker, Bartholow, Gross, Flint, Clark, Loomis, Bumstead, T. G. Thomas, H. C. Wood, Goodell, Fothergill, Davis, Marion Sims, Byford, Janeway, Da Costa, Solis Cohen, Clymer, J. Lewis Smith, W. H. Thomson, Brown-Séquard, Pallen, Hammond, and others. Many of the formulæ will be recognized as coming from the larger hospitals and dispensaries of New York and other cities. Such formulæ generally become incorporated into the armamentarium of the physicians who have served in these hospitals. The book may have a limited usefulness to the young practitioner who has not yet found out for himself how best to combine drugs. E. S. B.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

With the active collaboration of

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LEADING ARTICLE.

LAPAROTOMY FOR PENETRATING WOUNDS OF THE ABDOMEN.

Since the publication of Senn's application of hydrogen gas in the detection of wounds of the hollow abdominal viscera, a resumé of which was presented to the readers of THE ANALECTIC on Aug. 2, 1888, a new impulse has been given to the discussion of the treatment of penetrating wounds of the abdomen. In quite an elaborate article in the *Boston Medical and Surgical Journal* (Oct. 18, 1888), Dr. W. B. Coley has collected the histories of seventy-four cases of gun-shot wounds, which he divides into three classes with reference to the time intervening between the injury and the operation:

Class 1 contains only those cases operated upon within the first twelve hours.

Class 2 contains cases operated upon after twelve hours.

Class 3 contains cases in which the time of operation could not be ascertained.

Class 1 contains 39 cases; 18 recovered, 22 died. Percentage of recoveries, 43.6.

Class 2 contains 22 cases; 5 recovered, 17 died. Percentage of recoveries, 22.7.

Class 3 contains 13 cases; 7 recovered, 5 died, 1 doubtful. Percentage of recoveries, 57.

The above classification shows very clearly the advantage of an *early* operation, the percentage of recoveries in cases operated upon during the first twelve hours being nearly double that of cases operated upon after twelve hours.

Total number of cases operated upon	74
Number of recoveries	29
Percentage of recoveries	39.5

Causes of Death in the Cases that did not Recover.

Hemorrhage	4 cases.
Peritonitis	9 cases.
Shock	8 cases.
Wounds not found by operator	4 cases.
Pneumonia	1 case.
Acute peritonitis	1 case.

Dr. Coley calls attention to the difference between these figures and those presented in the histories of the cases in which no active interference was attempted. Dr. E. M. Moore has collected 4,463 cases of shot-wounds of the abdomen. Of these, 3,662, or 82.7 %, died. He says that to these should be added a certain number who died without medical attendance, which would probably make the percentage of recoveries less than ten. Of all these cases there were only five cases of recovery from wounds of the small intestine. There were 650 cases of penetrating wounds of the abdomen reported in our civil war, yet Dr. Otis, in the "Surgical History of the War of the Rebellion," says: "It may be doubted if a single incontestible case of recovery from shot-wound of the *small* intestine was observed.

The following case is reported by Roswell Park, A.M., M.D., in the *Medical News* (Aug. 4, 1888). It is included in Dr. Coley's table. The patient had been

injured at eleven o'clock in the forenoon ; at about three the operation was begun. In the meantime he had rallied well from the shock, and was urgent that the operation should be undertaken. Incision was made in the median line, chloroform being the anæsthetic. "There was a good deal of blood in the pelvic cavity, to remove all of which I had to prolong the incision downward, and to lift out all the pelvic viscera. There was no injury to any of the pelvic contents. Exploring higher, I had to extend my incision well toward the sternum, and there found that blood was trickling from some point well up toward the diaphragm. After long, careful, and diligent search, I found a perforation in a loop of small intestines up behind the colon. There was no tendency to eversion of its mucous lining, so I closed it with a Lembert continued suture of fine silk; but the bleeding did not come from this point. On exploring further, it was only after lifting up the stomach that in a neighboring concealed loop I found another perforation with eversion and a long rent along the mesenteric border. These were closed with Lembert sutures, but with great difficulty, since they lay so deeply, and since the mesentery was so short. After careful examination I could find nothing more in the abdominal cavity ; so I closed the abdominal wound with numerous silver sutures. The wound of the abdominal parietes I irrigated and drained with very small rubber tubes, and closed with an antiseptic, occlusive dressing. The operation altogether continued about one hour and forty minutes. The patient rallied from the shock ; was given morphine hypodermically, and became comfortable during the night. He was only disturbed by belching of gas, which occurred frequently. The next morning his temperature was 99¼°, his pulse 110, and his general condition most satisfactory. In the evening his pulse began to fail, and his temperature to rise. At 1 A.M. he evidently began to sink, and toward morning became unconscious. There had not been any distension of the abdomen, and his pulse did not present the usual features of the pulse of acute peritonitis. When I saw him at 2 P.M. he was comatose, his pulse scarcely perceptible. The abdomen had shrunk rather than distended, so much so that his dressings seemed a little loose. On placing my ear over the heart, a very loud pericardial friction sound was heard. This was so loud, in fact, as almost to obscure the other cardiac sounds. He was beyond help, and died at 3 P.M., fifty-three hours after the injury, and forty-seven hours after completion of the dressing. A partial autopsy was made next day by Drs. Nichol and Straight. They informed me that the wounds we had sewed were found perfectly united ; that no leakage had taken place ; that in some places the stitches were covered out of sight by plastic lymph. Only slight local peritonitis was found, and the long incision in the abdominal wall had healed by first intention. There had been no hemorrhage, and altogether every thing in the abdomen was in as satisfactory a condition as could be expected or desired. The thorax was not opened, consequently nothing can be told about the pericardium. Acute pericarditis is an occasional result of surgical conditions of greater or less magnitude, but we are still utterly in the dark as to its etiology."

Dr. John H. Packard (*Med. and Surg. Reporter*, Jan. 5, 1889) reports a case of injury by a circular saw, in a boy of twelve years, in which there were three wounds of the intestines, several rents and contusions of the omentum, and in which the exposed peritoneal surface was covered with woollen shreds derived from the clothing of the boy, that was followed by complete recovery, after sewing up of the rents, removal of the jagged portions of the omentum, and careful picking off the shreds of cloth, with thorough cleansing of the abdominal cavity. The favorable features in this case were the youth of the patient, and the complete plugging up of the wound in the abdominal wall by the extruded intestines, during the removal of the boy from the place of injury to the hospital.

In the *Weekly Med. Review* (Nov. 10, 1888) a case of injury to the stomach is reported by Dr. Dalton which was not detected by Senn's method, as proper precautions were not taken to have the patient so placed that the wound should be at the highest point, and so allow the escape of the hydrogen gas. Dr. Senn (*Med. News*, Aug. 25, 1888) reports a case of his own, in which these precautions were taken, enabling him to make a positive diagnosis of perforation of the stomach.

GERTRUDE B. KELLY.

OCCASIONAL REPORT ON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Galezowski : Some Words on Glaucoma. — At the last Congress at Heidelberg, taking part in a discussion on the subject of glaucoma, I directed the attention of specialists to a new operative procedure that I have applied for some time past in simple glaucoma with quite fair success, and to which I have given the name of *posterior sclerotomy*. If the pathogeny is still badly defined, the therapy is not less uncertain, for neither iridectomies, nor myotics, nor even sclerotomies give any sure results. This last operation, which I have performed quite often in simple glaucoma, seems to me to only retard the march of the disease, but one is obliged very frequently to repeat it after some months, and finally sight is lost in spite of two or three sclerotomies made at long intervals. In view of these failures, and knowing that in this form of glaucoma the anterior portions of the eye do not present any appreciable disturbance in the circulation of the globe, I have thought that the excavation of the papilla is occasioned by a morbid process of the posterior segment of the globe. I am led to this opinion by the anatomico-pathological researches on a glaucomatous eye enucleated by me, and confided to Dr. Latteux. This gentleman has found a much greater density of the sclera and an atheromatous alteration of the vessels of the posterior segment of the globe. Dr. Hache, pupil of Prof. Ranvier, has arrived at similar results before. The thickening of the sclera hence can have a certain pathogenic significance in the development of simple glaucoma: an obliteration of the posterior capillary vessels, an obstruction of the circulation at the periphery of the optic nerve, and a consequent excavation of the papilla can be due to it. Priestly Smith, in a remarkable report that he made to the Congress, admits also the probability of these alterations when he says, paragraph 6: "The senile alterations of the vitreous, which should put an obstacle to filtration towards the anterior chamber, are possibly among the number of predisposing causes, *so can*, but in a less degree, *the rigidity of the sclera and the senile degeneration of the vessels*."

To re-establish the circulation in the posterior segment of the globe, I have practised, with fair success, already four times, the following operation by means of a specially curved knife that I call a *sclerotome*. I detach the capsule of Tenon beyond the ciliary circle with a sclerotome in two places, taken between the superior rectus, the external rectus, and inferior rectus. I then thrust the knife into the substance of the sclerotic, and before withdrawing it, lengthen the cut in the antero-posterior meridian. This incision, a few millimetres in length, is not stopped until the sclerotic and choroid are surely penetrated. Having made these two incisions, instill eserine into the eye and apply a compress and bandage. Some days after the wound has healed one will find on examination nothing more than a few red hemorrhagic patches on the choroid, transformed by atrophy in a few weeks. As to vision, this is immediately improved, and visual acuity becomes better, and the internal visual field slowly extends in extent; but is not the most important, for the disease is found to be completely arrested by this operation—delicate, it is true, but not at all dangerous. Finally, this operation is destined to render to simple glaucoma better results than all that has been done and employed to the present, and I think much is due to the peculiar knife I have constructed for it.—*Rec. d'ophthal.*, October, 1888.

Pardee (G. C.). Some Clinical Notes on the Use of Eserine in Glaucoma. —The reason for presenting the twenty cases which have come to me during three years is to call attention to the beneficial, even curative, effects of eserine in certain cases of this most terrible disease. Out of 22 eyes where treatment was attempted, 8 were operated upon, 7 by iridectomy and 1 by sclerotomy. All of these were improved, though in some the improvement was very slight. In all of these eserine was tried without any effect whatever. In the remaining 14 cases eserine took the place of an operation, and the improvement in several of them was very great; in fact, the improvement following the use of eserine, when improvement followed its use, was much greater and more satisfactory than in the operated cases. It is true that the cases operated upon were more stubborn, but would have resisted the iridectomy alone, I believe, as well as the eserine alone.—*Pacif. Med. and Surg. Jour. and West. Lanc.*, Nov., 1888.

Strawbridge (Geo.): Preliminary Report of an Operation for the Formation of an Artificial Pupil through the Sclerotic Coat of the Eyeball.—Two operations for grafting a rabbit's cornea upon the human cornea showed the uselessness of it. Then the idea occurred of preventing the oozing through an artificial opening with transparent media, of the eyeball fluids by using a flap of the conjunctiva near the cornea which is nearly transparent. Six operations for artificial pupil through the sclera posterior to the ciliary bodies were made upon rabbits, the conjunctiva first being dissected away and inverted and the rectus muscle divided. A v. Hippel trephine, 4.5 mm. diameter, was used to make the opening in the sclera in four of the operations, in one of which two thirds of the opening was through the ciliary body without special irritation. In two operations a Graefe cataract-knife was used to make a triangular opening. The motor power for the trephine was a dental engine, which proved very successful. Two operations were made upon the cornea, but in both, the conjunctival flap, though it remained in position, was opaque. But in the scleral cases, at the end of six weeks the openings show themselves like dark pupils covered by a three-fourths transparent conjunctiva. There is no tendency in these openings to close, and there will surely be a most serviceable amount of vision through them. On Dec. 4th I made two scleral pupils on the human eye. The progress so far corresponds to that of the operations upon the rabbit, though it is still too early to verify results. The risk to the globe is small.—*Med. News.*, Dec. 15, 1888.

Wolfe (J. R.) on the Treatment of Ulceration of the Cornea and Keratoconus by the Actual Cautery.—Like Odysseus, when he charred Polyphemus' single eye, we may use the cautery with benefit for cancer of the orbit or for nævus. But in ulceration of the cornea, where our object is to treat the cornea without leaving behind a scar, or as little as possible, the use of the cautery is most objectionable. As to the use of the cautery in keratoconus, we shall be only adding more confusion to an already confused vision. The cautery in any form or shape does, in my opinion, absolutely no good.—*Provin. Med. Jour.*, Dec. 1, 1888.

Barck (C.) on Massage in Eye Diseases.—This procedure has been proved of use in many chronic diseases. And it is no less applicable to certain forms of chronic inflammation of the eyes. It is of course applicable only to affections of the external portions, the lids, sclera, and cornea. The method of its use will modify its success. If movement is made over both upper and lower lids, especially the lower, with moderate pressure, better results are obtained than where the procedure is confined to the upper lid, its use here being at times painful. As elsewhere, the procedure should be methodically applied at stated intervals, and each time for the definite period of four to five minutes. I am of the opinion that massage, added to the usual medication, if regularly and methodically employed, yields results not attained by any other treatment, and recommend it earnestly to the profession.—*Weekly Med. Rev.*, 1888, p. 483.

Kipp (Chas. J.) on Nystagmus Occurring during the Course of Disease of the Ear.—Three cases are described, and a review of the literature on this very interesting symptom given. The general features of the new cases were, that during an exacerbation of a previous attack of otitis media purulenta, dizziness and nausea came on with a sense of falling towards the affected side. During this condition nystagmus appeared, in one case without provocation, in the others by pressure upon the tragus, or sometimes from syringing the ear. On being induced the symptom continued for a varying period afterwards, from one minute to many days and even years. It was preceded in some instances, where the provocation was more decided, by a violent jerk of the head towards the affected side, with, in one instance, a darkness of the field of vision and nearly a loss of consciousness. The movements were towards the affected side in a horizontal plane, preceded in a few instances by a few slight movements in the opposite direction. The theory of the production of this nystagmus is the same as given by Hughlings-Jackson and Schwabach, viz.: irritation of the semicircular canals through pressure on ossicles and drum; there being no doubt an increase in the amount of fluid in the canals themselves at the same time. Ten cases have been found recorded by Bürkner, Urbantschitsch, J. Hughlings-Jackson Jacobson, Gruber, Moos, Schwabach, and E. Pflüger.

Besides these recorded cases Cyon and Högyes have recorded experiments on animals, where irritation of the semicircular canals produced bilateral movements of the eyes, Högyes expressing the opinion that the vestibular terminations of the acoustic nerve are a peculiar terminal apparatus which regulates the movements of the eyes and probably the movements of all the muscles subservient to the maintenance of equilibrium, according to the position of the head or the body.—*Trans. Am. Otolog. Soc.*, 1888.

Burnett (C. H.) on Inflammation of the Tympanic Attic.—The present is a summing up of previous communications, with the report of ten new cases, or twenty in all. The disease has been described by American and German surgeons only. The disease occurs more frequently in males, 13–7. Internal tympanic disease was the cause in 15 cases. The perforation in half of the cases was central. In 15 of the 20 cases only one ear was affected. In 11 cases polypi existed. Children are not liable to this form of ear disease. In many instances it comes on without pain and is chronic from the first. Its relative frequency in my practice is 1 per cent. of all cases, as in the practice of Bezold. The hearing is greatly impaired though often temporarily improved after the washing out of the attic. The discharge is thick and scanty and offensive. There is rarely a perforation whistle. *Treatment:* The chronic form of purulent inflammation is difficult to cure, especially when starting from within, but the others, the traumatic, are easily managed. Where the perforation is large, medication and drainage being better, the cure is easier. Cleansing and antisepsis, the latter especially by peroxide of hydrogen and carbolic acid, are the best forms of treatment. The tympanic syringe of C. S. Blake is of great assistance. Aqueous solutions of zinc, bicarbonate of sodium, chloride of sodium, lead, and copper may be used. Powders are impotent. All forms of escharotic and cauterant treatment are not well borne, as the inflammation and swelling caused prevent drainage. Drainage is so important that it has been suggested to obtain it by surgical interference, and I feel sure that a radical cure can be best obtained this way.—*N. Y. Med. Jour.*, Nov. 24, 1888.

DISEASES OF THE ORBIT.

Dr. R. A. Reeve, of Toronto, in an article on diseases of the orbit, says[1]: "If eyes which are blind, painful, and hard were looked upon with suspicion, and, as a rule, extracted, after a fair trial of proper means, there would be less fatality from sarcoma or other malignant disease. In an eye that was blind, hard, and intensely painful, which I enucleated eight years ago, a malignant tumor had just penetrated the sclera near the optic nerve. Fortunately, all the diseased tissue was removed, and the patient was reported in good health and free from orbital disease several years afterwards."

Referring to the question of prophylaxis in malignant orbital disease, Reeve adverts to another class of cases in which the disease primarily attacks the lids or superficial parts. In such cases there is a double reason for an early operation: first, because the sooner done the less of the normal tissue is lost—an important point in the region of the eye; secondly, for the reason which applies universally in malignant disease. In subjects of fifty years and upward little or no harm would accrue, and much trouble or misery might be saved were all warts, tumors (not chalazia), and ulcers of the lids treated as if actually malignant, or at least in "pre-cancerous" stage.

The following is a resumé of a case of living and dead osteomas of the nasal and its accessory cavities, published[2] by Christian Fenger, of Chicago:

M. M., aged twenty-four years, tailor, was admitted to Cook County Hospital, April 27, 1887. He gave the following history: Parents lived to old age, and there is no history of tumors or deformities in any of his ancestors or relatives. Patient had measles when a child, but otherwise has always been strong and healthy. He dates his present illness from 1878, when he was struck by a club at the inner canthus of the right eye, causing a fracture of the bones of the nose. In the course of a year a swelling appeared and increased slowly, and without pain in the abovenamed region caused the right eye to be pushed outward. He thinks the swelling has remained stationary for the last eight years. Five years ago a discharge of pus

[1] *The Canadian Practitioner*, September, 1888.
[2] *Jour. Am. Med. Assn.*, Aug. 11, 1888.

from the right nostril commenced, and has continued ever since. Four months ago an abscess formed at the inner canthus. It was opened, and left two fistulous openings, which discharge a moderate amount of pus. Present condition: The patient is well nourished, somewhat pale, but otherwise looks healthy. On the right side of the root of the nose is a flat prominence, which fills up its inner third from the superciliary arch down to the infra-orbital ridge, and extends a little in front of the bridge of the nose. The superciliary region of the frontal bone—that is, the anterior wall of the frontal sinus—is not enlarged or pushed forward. The skin covering the tumor is normal, with the exception of a red inflamed area around the two fistulous openings. The probe introduced through these finds roughened bone near the surface, and the entire tumor feels hard, as if consisting of bone covered only by skin. The infra-orbital margin can be traced to within a line or two inside the infra-orbital foramen, where it gives place to the hard tumor arising from below. The eye is pushed downward and somewhat outward, and on examination by Dr. E. M. Smith, oculist to the Cook County Hospital, presents the following condition: Right eye deviated outward and downward; distance from nasal crest to pupil on left side, 30 mm.; on right side, 50 mm.; consequently the outward deviation is 20 mm.; deviation downward, 10 mm.; exophthalmus, 7 mm. There is slight hypermetropia, the pupil is active, the tension of the eyeball normal. Ophthalmoscopic examination shows the fundus normal, the optic disc not swollen, but the veins are somewhat engorged and tortuous; acuteness of vision good. Inspection of nose shows, an inch and a half inside the nostril, instead of the inferior and superior meatus and the concha, an irregular mass covered with bluish-red mucous membrane, and to which several small polypi the size of a pea were attached. The infra-orbital region is somewhat prominent in its nasal half, but no distinct tumor can be felt behind the upper lip above the alveolar process of the upper maxilla. Inspection of the mouth and palate shows no difference between the two sides, and the soft palate and pharynx are normal. Rhinoscopic examination is impossible on account of the thickness and size of the soft palate, the movements of which the patient cannot control. Palpation of the naso-pharyngeal cavity with the finger reveals a hard, irregular, rough, bony mass filling up the right posterior coana. A small exploratory incision, enlarging the fistulous opening of the tumor in the inner canthus, showed the roughened bony surface of a large osseous tumor, which was hard and immovable.

Diagnosis.—Orbital osteoma originating in and being part of a large ethmoidal osteoma. The place of origin either in the lower medial point of the frontal sinus or in one of the ethmoidal cells.

Operation.—A longitudinal incision was made midway betwen the eye and the root of the nose, commencing on the frontal bone an inch above the orbit and extending downward three inches to the ala of the nose. The incision having been carried down to the tumor, the soft parts were detached by a gouge from the anterior and orbital surface of the latter. The tumor was found to extend far back in the orbit, from an inch to an inch and a half. The surface of the tumor is very hard and the tumor itself is movable. With a view of getting at the base of the tumor, if it existed, or rather, of uncovering the mass of the tumor, I removed with the chisel the nasal and frontal portions of the superior maxilla and the right nasal bone, together with the nasal process of the frontal bone. Having thus opened the frontal sinus I was so fortunate as to find the end of the tumor reaching up, with only a small corner which was not attached to the walls of the frontal sinus at all. Through the large lateral opening into the nasal cavity, the tumor was found filling it up, and by grasping with a firm bone forceps, it was easily made movable and brought out through the opening. The bony tumor which was formerly felt in the posterior nerves was still there, but it was loose and was removed through the same opening as the other tumor. There was now left a large cavity opening into the frontal sinus and posterior nares, and the nasal and submaxillary cavities below. In the orbit, the periosteal covering of its inner wall was intact, covering the eye and its accessory organs. The remainder of the cavity was covered with its mucous membrane, on which several small polypi were found and removed. There was no considerable hemorrhage, and the wound was united, and the cavity washed and packed with iodoform gauze. With the exception of a

slight rise in temperature on the second day, the course of the after-treatment was aseptic. The iodoform-gauze dressing remained until the close of the second week, at which time the wound had united.

Description of Tumor. The living osteoma weighs two ounces, measures 2½ inches in length and 1½ inches in diameter; it is irregular in shape, since it consists of several portions, corresponding to the different cavities which it occupied. These portions, separated by distinct depressions from the central body of the mass, are: 1. The orbital portion which forms a rather square mass of bone, measures 1½ inches from above downwards, 1½ inches in antero-posterior, and ¾ inch in transverse diameter. Its anterior ridge is denuded and roughened, while the rest of the tumor is covered with periosteum and a thick layer of mucous membrane. The orbital portion reaches from the internal anterior border of the orbit back to the orbital foramen. From the upper inner corner of the orbital portion a small round projection the size of a pea extends up into the frontal sinus. 2. The portion occupying the antrum of Highmore is a rounded pyramid, ½ inch broad, ½ inch high, and occupies the cavity mentioned, the nasal wall of which has disappeared. 3. The nasal portion, which forms the bulk of the osteoma, is an irregular square of the above mentioned diameter in all directions; its inner surface is covered with a thick layer of mucous membrane, from which three mucous polypi the size of a pea have grown out. At the anterior upper corner of this nasal portion is a large polypoid growth ½ inch long, ¼ inch broad, pedunculated. It contains a small bony nucleus the size of a pea; in other words forms a small osteoma, by means of a pedicle movable against the large tumor, in which there is a small depression into which it partially fits. The posterior inferior surface of the nasal portion is concave, 1 inch in diameter, covered with a thick layer of smooth connective tissue. The concave surface forms a cup into which the upper rounded surface of the dead osteoma, so to speak, articulates. On the middle of the inner surface of the nasal portion is found a square plate of the ethmoid bone ½ inch in diameter, which I consider the point of origin of the osteoma.

The cut surface of this large osteoma shows a peripheral layer ¼ inch in thickness, of extremely hard, compact osseous substance; so hard that a sharp chisel or knife will only with difficulty cut into it, and a smaller central area of cancellous substance, which is so friable as to be penetrated with considerable ease with sharp instruments.

Microscopic examination of the layer of soft tissue covering the tumor shows the following: A layer of cylindrical epithelium, under which is a heavy layer of mucous membrane proper, containing numerous tubular mucous glands. Finally, nearest to the bone, a layer of fibrous tissue constituting the periosteum.

The dead osteoma is about 1½ inches long, ¾ to 1 inch in diameter. Its upper surface, which has articulated in the above-described cavity in the large tumor, is rounded, slightly nodular, smooth and hard, like ivory. The rest of the surface is uneven and roughend. Parts of the tumor had been broken off, so that when the whole tumor is put together it would form a large mass of the size of a walnut. The broken surface shows this to consist of a very thin outer shell of very hard compact bone substance, and within a mass of fine spongy substance, resembling pumice stone.

On the dead osteoma there is nowhere a trace of any membrane covering it, and it emits a penetrating fetid odor. No odor at all emanates from the living osteoma.

J. A. ANDREWS, M.D.

Alleman (L. A. W.) on Dermoid Cyst of the Orbit Simulating an Osteoma.—The parents of a child of three stated that for a year past they had noticed a lump on the left eye. Upon examination a small tumor was discovered at the roof of the orbit, on the temporal side. It could be plainly distinguished by pressing the tip of the finger back into the orbit above the globe. The tumor seemed to be hard and immobile, not at all sensitive on pressure, and did not appear to give the patient the least pain or inconvenience.

The child seemed to be in perfect health, and no history of injury could be obtained. The patient was kept under observation for several days, no change taking place in the tumor during that time. The tumor seemed in November to have slightly increased in size, and Dr. Derby removed it. A curved incision was made through the skin just below the margin of the orbit, and the tumor carefully dissected down upon. Greatly to our surprise the lachry-

mal gland was found pushed forward in front of the tumor and held firmly in place. Behind this was found and removed a sebaceous cyst. This cyst had pushed the lachrymal gland before it, and held it so firmly fixed that, on the very imperfect examination that was alone possible, it appeared to be a bony tumor springing from the roof of the orbit. — *Brooklyn Med. Jour.*, Jan., 1889.

Rockliffe on Suppurating Hydatid Cyst of Orbit.—The patient, a laborer, aged 33, had first noticed an affection of the sight of the left eye in 1882. He had several attacks of inflammation in it, and the vision gradually deteriorated, till in April, 1887, he was quite blind with it. There was then marked protrusion, some ptosis, and the action of all the ocular muscles, except the external rectus, was very limited; nothing definite was made out as to the condition of the orbit. Eighteen months later, having had more attacks of pain, the patient consented to an operation. An exploratory puncture with a scalpel having given no result, the orbit was more freely opened up, and the eye being removed, a suppurating hydatid cyst was found at the apex of the orbit.

The patient attributed the suppuration to a blow with a piece of iron. No hydatids could be found elsewhere. The author thought the cyst had developed behind the eye, and had not been attached to the muscles, for the patient had free movement in every direction. — *Brit. Med. Jour.*, Dec. 22, 1888.

MISCELLANY.

McLean (M.) on Intra-Uterine Cry after Expulsion of the Waters.—In August last he was asked to assist Dr. Tracy in delivering a woman at term. Dr. McLean had attended her in four previous normal confinements. On this occasion the occiput was in the posterior position, and while he was trying to rotate the head forward with his hand the nurse drew the patient into a hollow in the bed, whereupon the abdominal organs receded from the pelvis, air rushed into the vagina and uterus, and immediately the child began to cry. The crying continued while he rotated the head, applied the forceps, and extracted, or during about five minutes. It was somewhat remarkable that material was not insufflated, interfering with breathing.—*Med. and Surg. Reporter*, Jan. 26, 1889.

Van Winkle (J. O.) on Antipyrine during the First Stage of Labor.—The first dose was given when the os was about one third dilated, except in cases where the pains were very severe from the outset, when it was ordered earlier. Antipyrine, gr. xv., and spt. ammon. aromat., ℥ xxx., were administered every two hours during the first stage for three doses. The temperature and the pulse were noted at the time the first dose was administered, and every hour thereafter until dilatation was complete.

In almost every instance the patient said she felt greatly relieved, and this was evident from her behavior. In some cases the patient would fall asleep for an hour or so after the first or second dose. These observations were all the more important since the class of patients delivered in the maternity hospital includes many nationalities and social conditions, conspicuous among them being many Polish Jewesses and Bohemians, who, as a rule, are very restless and demonstrative during confinement, and the effect on these was quite noticeable.

Incidentally it was observed that generally the temperature fell from half a degree to a degree and a half, F. The pulse became somewhat more frequent, and the respiration slightly increased. Occasionally, if the pulse was rather rapid before administering the drug, it decreased in frequency.

From experience it is apparent that antipyrine does not increase the duration of labor, but, on the contrary, tends to lessen this stage on an average of about half an hour, while the second stage remains practically the same, and in no case was there any injury done the mother or child.

Thus we see that the results of carefully kept statistics go to substantiate the statement made by Dr. Grandin—namely, that antipyrine very materially lessens the severity of the pains during the first stage, without increasing the duration of the labor and without in any way injuring either the mother or child. The drug has never given rise to alarming symptoms, and this immunity is doubtless due to the fact that we have always associated it with a stimulant, and further to the fact that during labor there exists a physiological stimula-

tion of the heart's action.—*N. Y. Med. Jour.*, Jan. 5, 1889.

[Dr. Talbot Jones, of St. Paul, Minn., has employed antipyrine in labor, and attributes [1] its beneficial action to its power to lower reflex irritability, and dull but not abolish sensibility. He has never seen any bad effects from it. He thinks it less potent when given by the rectum, and recommends larger than 30-grain doses. He advises smaller doses to delicate blondes, asserting that they are peculiarly susceptible to it.]

Cancer of the Uterus in Childhood and Youth.—Not only has sarcoma, but also true cancer of the vagina, been observed in children two or three years of age. Schauta has described a case of malignant adenoma of the cervix in a girl aged seventeen. It was cut away, but recurred locally several times, till it spread to the right parametrium, forming a large tumor which caused the patient's death. The supra-vaginal part of the cervix was found intact. Rosenstein described, some years since, an interesting case of cancer of the fundus uteri in a child aged two. A solid tumor reached high above the symphysis, causing dysuria. The inguinal glands were swollen. After death, a large mass was found projecting from the right side of the fundus, another from the left side; the latter was softening. Deposits covered the anterior peritoneal surface of the bladder. The uterine mucous membrane, cervix, tubes, ovaries, and vagina were healthy. Though, under the microscope, the tumor appeared in parts of sarcomatous character, in others it was truly cancerous. Eckart has noted a case where a large mass which filled the vagina sprang from the cervix of a girl aged nineteen. The growth was apparently rather a sarcoma than a cancer. Professor Ganghofner, after noting the above cases, describes in the *Zeitschrift für Heilkunde*, 1888, a case where the cancer attacked the vaginal portion of the cervix of a girl aged eight. For two or three years blood kept escaping from the vagina. The growth was fungous and very brittle; it was confined to the anterior part of the cervix, and the vagina was quite free from disease. The tumor was carefully cut away, and its base ("of the size of a twenty-kreutzer piece") cauterized. Under the microscope it proved, according to Professor Chiari, to be a medullary glandular carcinoma. The poor little patient took confluent small-pox in hospital, and died eleven days after the operation. No secondary deposits were found, and no glands were enlarged.—*Brit. Med. Jour.*, Jan. 5, 1889.

Cameron (H.C.) on Ovarian Tumor Removed from a Child.—A little girl of 3½ years was admitted to the hospital on 29th May, 1888, with a marked swelling of the abdomen. It seemed to have begun three or four months before that time. This enlargement had not been associated with febrile or any other general disturbance, and had not disordered the action of the bladder or bowels. An examination of the various organs gave negative results except as stated below. The abdomen measured 29 inches at the umbilicus, and on examination it at once seemed obvious that the swelling depended on a tumor occupying chiefly the right part of the abdomen, but traceable, on deep pressure, as extending a little to the left of the middle line also. The upper part of the tumor could be easily traced by the hand, but the lower portion could not be accurately defined, and pressure in this situation caused pain. The tumor gave the impression to the hand of deep fluctuation or elasticity, and it presented a certain mobility from side to side. On percussion the whole tumor was dull, and no change occurred on shifting the position of the patient. A marked hernial protrusion. into the left labium, was easily reduced. Two oz. of urine were drawn off without affecting the tumor in any way, the urine itself was natural.

On admission, and for some days thereafter, there were indications of only a little fluid in the peritoneal cavity, but a fortnight after admission a rapid increase occurred, the abdomen increasing to 31 inches, evidently due to the accumulation of fluid in the peritoneum: the tumor could not be defined, but on deep palpation it could be felt as a movable body. A little rubbing or crackling at the left margin of the tumor was detected on manipulation a few days before the operation; it was thought to be due to peritoneal friction.

The most striking phenomena associated with the tumor were the evidences of changes such as occur at puberty. The mammæ had enlarged with the appearance of the abdominal swelling; they were on

[1] *Northwestern Lancet*, Jan., 1889.

admission notably developed, not hard, but with quite a glandular feeling on touching them; no secretion had ever been observed to come from them; there were no areolæ at the nipples, but a few hairs of fine texture were seen on the breasts. The labia pudendi were full and presented a small development of hairs such as is seen in incipient puberty; there were no hairs in the axillæ. There was a well marked black line extending from a little below the umbilicus down to the pubes. Some discharge of clear matter was described as coming from the vagina occasionally, since the swelling appeared, and some gelatinous material seen there after admission was found to contain much epithelium but no pus.

In view of the character of the tumor, and the concurrent evidences of precocious puberty, the diagnosis of ovarian tumor was made with some confidence, and shortly before the operation the evidence of rapidly increasing peritoneal effusion was complete.

On removal, the tumor was found to be a round-celled sarcoma weighing 3½ lbs. Such profound shock followed the operation that bleeding from the pedicle was suspected, but none was revealed on autopsy."—*Glasgow Med. Jour.*, Jan., 1889.

Hamaker (W. D.) on a Case of Complete Absence of the Uterus.[1]—The woman, twenty-three years of age, had never menstruated, nor had had any of the symptoms of menstruation, and there was no history of vicarious menstruation. She had married at the age of nineteen years, and her married life had always been happy. Sexual intercourse is pleasurable. She has always had excellent health, and says she never had an.ache or pain.

Her breasts were well developed and the pelvis wide, and the whole appearance was that of a woman with complete development.

Upon inspection of the external genitals nothing abnormal was noticed. The pubis and labia majora were covered with the usual growth of hair. The clitoris was of normal size and appearance. Under chloroform, the vagina was found to be extremely short, being not more than an inch and a half long, and to terminate in a *cul-de-sac*, which was symmetrical and smooth and contained no trace of a cervix.

By combined abdominal and vaginal palpation, no swelling, hardness, or fluctuation could be detected. Negative results were also obtained by combined rectal and abdominal palpation. No ovaries could be detected.

On inspection of the vagina by means of the speculum, it was found to be of natural size throughout its entire length, and its wall presented a natural appearance. There was no prominence or depression at any point to indicate an os uteri or a rudimentary cervix.

When she was not under the influence of the anæsthetic no tender point could be found either by vaginal examination or by deep pressure over the ovarian regions.—*N. Y. Med. Jour.*, Feb. 2, 1889.

A Challenge.—The following offer should aid somewhat in clearing up the mysticism hanging about the Apostoli method of treating uterine fibroids:

PITTSBURG, PA., Jan. 11, 1889.

E. S. McKee, M.D., Cincinnati, O.:

MY DEAR DOCTOR:—In the *Lancet-Clinic* of January 5, 1889, I quote from your most entertaining paper, read before the Academy of Medicine, the following language: "To the general practitioner the method of Apostoli offers an efficient substitute for the knife, which they have so generally feared in cases of fibroid tumors. . . . The method (Apostoli's) is truly that of specialists, and the condemnation of every bungler who undertakes it and fails should not be heeded. Though one may, with very little knowledge of electricity, effect cures, yet it is advisable to be well posted in electro-therapeutics before undertaking to manage currents of such intensities as are now employed."

No doubt you use this language because you know from personal experience that it is true, and therefore fair. I take it that your unconditional statement is the result of scientific conviction. I will place at your disposal three women, each with a fibroid tumor, sustain them at my own cost in my private hospital, sustain you also and furnish you with a perfectly complete apparatus and all else you may require, and for every one of these tumors you remove by your "efficient substitute for the knife" I will pay you one thousand dollars. But if you fail, you to pay the expenses of sustaining the women and yourself.

[1] See preceding number MEDICAL ANALECTIC, p. 58.

For the removal of the tumor you must name the time required. It must not exceed one year in any case.

Very truly yours,

R. STANSBURY SUTTON.

—*Cincinnati Lancet-Clinic*, Jan. 19, 1889.

Reid (T.) on a Case of Sarcoma of the Skull.—A child of twelve came to the infirmary on January 16, 1888, with a small, soft, semifluctuant tumor almost in the middle line of the forehead, and slightly above the line of the supra-orbital ridge. The growth had appeared two months previously, so that it is now a year since it was first detected. There was also another swelling about the size of a cherry in the lower segment of the right upper eyelid; it was freely movable over the tarsal cartilage. This growth appeared a month later than the other, and at the date of first examination the skin covering it, though not adherent, was of a deep purplish chlor, with enlarged veins. The case was again seen on April 2, 1888, when it was found that the tumor had much increased in size, extending towards the right side, and not at all to the left. The tumor of the eyelid was enlarged, but still distinct from the other. The sense of smell was found to be perfect in both nostrils, while with the ophthalmoscope a typical double optic neuritis was discovered.

During the summer there has been a steady increase of the tumor—an increase, however, till recently confined to the right side of the forehead.

Now the tumor is beginning to cross the middle line, and is rapidly invading the left upper lid. The sense of smell is impaired, only the more pungent odors being detected. The general health has been good throughout.

The symptoms suggestive of brain implication are attacks of vomiting, unassociated with nausea, and accompanied by severe prostration, which have occurred at intervals of a fortnight during the past three months, the partial loss of smell known to have been previously perfect, and the changes in the fundus of the eye.—*Glasgow Med. Jour.*, Jan., 1889.

Stimson (L. A.) on Creolin as an Antiseptic.—This chemical is a dark, viscid liquid, with a tarry odor, insoluble except in alcohol, a 2 per cent. aqueous mixture appearing as a fine emulsion. He had been much troubled by the fact that secretions from wounds readily underwent decomposition under dressings of sublimate gauze, and had thus been led to try creolin. He had now employed it for two months with very satisfactory results, using ordinary purified gauze wrung out in a 10 per cent. aqueous mixture. The drug was rarely irritating to the skin. It was not only a good antiseptic, but it also arrested parenchymatous bleeding and hastened cicatrization. When applied to ulcerated cancerous surfaces, it was a powerful deodorizer. Chemically it closely resembled a cheap patented disinfectant, sold under the name of "soluble phenyl," but the latter was of somewhat thinner consistence; creolin contained no carbolic acid.—*N. Y. Med. Jour.*, Feb. 2, 1889.

Baines (A. H.) on Torticollis Cured by Operation.—A child of eight was brought to me for very pronounced wryneck, which had existed since birth, and was said to be due to injury during parturition. As the child grew the deformity became much more marked, so that at the time I saw her (at the beginning of January of last year) the head was drawn down and turned much to the right, the mouth and eyelids being drawn down, and giving an altered expression to the face. The corresponding shoulder was considerably raised, and the upper dorsal spine showed an incipient lateral curve. Seeing that mechanical contrivances would be of no avail, I advised immediate operation, which was wisely consented to. The sternal portion of the muscle was chiefly at fault, and the only one requiring division.

Passing a fine sharp-pointed tenotomy knife on the flat in front of this, about an inch above the clavicle, and then, on withdrawal, inserting a blunt-pointed tenotome, and turning the cutting edge against the tendon, with a sawing movement I proceeded to cut through it. To my surprise, this required more pressure than I expected, when suddenly, with an easily audible snap, it was severed, but, as the force used was under control, of course without injury to the underlying vessels. After the wound had healed, massage of the muscles of the neck and back was employed, and a weight was frequently carried in the hand of the affected side to draw the shoulder down. It is a complete cure, and there is now not the slightest deformity, the head and face being held in a vertical line, and the spine being again quite straight.—*Brit. Med. Jour.*, Jan. 12, 1889.

Patteson (R. G.) on Epithelioma in the Horse.—Epithelioma is an excessively rare disease among the domesticated animals, while among wild animals, living either in confinement or in their natural state, it is almost unknown. Mr. Bland Sutton has met with only two examples. One was in a Japanese wolf; the growth occupied the mucous membrane between the gums and the tongue, and presented the appearance of a leathery patch, resembling the chronic superficial glossitis—the so-called "ichthyosis linguæ," which occurs in man. The second growth occurred in the anus of a dog. Observers agree that tumors from the penis of the horse are generally fibromatous or papillomatous.

The specimens were obtained from a horse ten years old, from which two previous growths had been removed. The tumor was situated on the inferior aspect of the penis, involving also the sides and part of the upper surface of the organ. It was about 2¾ inches in length by about 1½ inches in width, the longest axis lying transversely. Its edges were raised, nodular, and everted; the surface irregular, with commencing ulceration. Microscopically it proved to be a typical epithelioma, the "cell nests" being specially well marked.

Another point of interest in the tumor is that, although originating in a part the epithelium of which normally contains pigment, yet in no portion of the neoplasm could pigmented cells be found.—*Dub. Jour. Med. Sci.*, Jan., 1889.

Conner (P. S.) on a Case of Sarcoma of the Scalp.—Primary sarcoma of the scalp is of such infrequent occurrence that I trust I may be pardoned for reporting a case recently under my care.

In October, 1885, I was consulted by a woman of 25, who stated that fifteen years before she discovered on the back part of her head a small hard lump, "of the size of a bean," not painful on pressure. For thirteen years there was no noticeable change in the tumor; but at the end of that time it began to enlarge, and continued to do so steadily until the time of her confinement (five months before I saw her), when the mass was "as large as a goose-egg." Since delivery its growth had been very rapid and attended with pain, at times severe. The woman was much emaciated and greatly enfeebled. The tumor, occupying the occipital region and looking much like a second head, was somewhat movable from side to side, and upon palpation pseudo-fluctuation was detected. It measured antero-posteriorly seventeen inches, laterally fifteen inches; its greatest circumference was twenty-one inches, and its least circumference, at the line of junction with the head, was fifteen inches. The tumor was removed on the 23d of October, the mass being readily and quickly separated with the fingers from the pericranium. The mass removed weighed almost five pounds, and upon examination proved to be a spindle-celled sarcoma. The woman left for her home on the fourteenth day.

For eighteen months (until May, 1887) she continued well, but at the end of that time noticed a small tender spot, and soon after a hard lump, which increased slowly for three months, and then more rapidly. She was about a month advanced in pregnancy when the recurrence was observed. After her confinement (in the middle of January of this year), very rapid growth took place, and when I saw her on the first of March, the mass measured antero-posteriorly eighteen inches, laterally seventeen and one-half inches, with a greatest circumference of twenty-five inches. Its surface was of a bluish color, and several large veins ramified it. On the third of March I removed it, making no effort to save any covering, but cutting along the line of junction with the head. The pericranium was in places included in the diseased mass, and was taken away. After the bleeding had been checked, the edges of the wound and the denuded surface were cauterized with the Paquelin cautery.

The mass, after removal, weighed seven and one-half pounds, and examination showed that it was a mixed spindle-and-round-celled sarcoma. Five weeks after the operation the patient left for home, the granulating wound being in excellent condition.

The points of special interest in this case are the years-long absence of any change in the original nodule, the marked influence of pregnancy and lactation upon the growth of the tumor both primarily and in recurrence, and, lastly, the immense size of the growth. The scalp is not seldom involved in sarcomata affecting the skull, but a primary tumor of such character located in it is exceedingly rare.—*Coll. and Clin. Record*, Sept., 1888.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

With the active collaboration of

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OCCASIONAL REPORT ON DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Daly (W. H.) on Some Mild Measures in the Treatment of Intro-Nasal Hypertrophies and Inflammations.—Dr. Daly makes what seems to be a timely and valuable suggestion in recommending multiple puncture of hypertrophied mucous membrane as a substitute for the more radical measures at present so popular. He cites several cases, and claims to have seen many others, in which it was possible to dispense with the snare, the galvano-cautery, and other destructive agents, by resorting to this simple and comparatively painless procedure.—*Med. and Surg. Reporter*, Nov. 17, 1888.

Baber (E. C.) on a Recent Improvement in Posterior Rhinoscopy.—A recommendation of White's palate-hook, with minute description of its method of application. It is found to be an assistance in examining as well as in operating. Besides the greatly improved view gained of the vault and back wall of the naso-pharynx (pharyngeal tonsil and bursa), it is possible to see farther into the posterior nares, on account of their appearing less foreshortened and better illuminated with the larger mirror. It may in certain cases also obviate a resort to the much more disagreeable procedure of palpation of the naso-pharynx.—*Brit. Med. Jour.*, Jan. 12, 1889.

White (Jos. A.) on Improved Means of Diagnosis in Nasal and Throat Troubles.—The author describes his post-nasal speculum, or self-retaining palate retractor, his self-retaining tongue depressor, and a rachet-snare and galvano-cautery handle.—*The Med. Register*, Dec. 15, 1888.

Potter (F. H.) on the Treatment of Acute Coryza.—In the absence of chronic intranasal disease and constitutional disorder, the author finds that the duration of a "cold" may be very much abbreviated by the use of a hot bath followed by $\frac{1}{100}$ to $\frac{1}{60}$ of a grain of sulphate of atropia, or 10 grains of quinine, when the former is known to disagree with the patient. These measures are adopted in the evening, and the patient afterwards goes to bed. The following day the nose is washed out with a warm alkaline spray, cocaine is applied to the mucous membrane, and the entire surface is then covered with a coating of "oleum petrolina." This process should be repeated twice in the course of the day.—*Buffalo Med. and Surg. Jour.*, Jan., 1889.

Mackenzie (M.) on the Treatment of Acute and Chronic Tonsillitis.—There are two forms of acute tonsillitis, superficial and deep. The former, although not serious, is painful and apt to recur. In the hands of this authority aconite has failed to exhibit the extraordinary virtue claimed for it, and he still recommends guaiac in the form of lozenge, three grains in each, one to be given every two hours. Local applications of bismuth and opium, or an eighth of a grain of morphia

with a quarter of a grain of starch, will relieve the patient's discomfort. If diarrhœa is caused by the guaiac, it may be checked, if necessary, by the morphia.

Parenchymatous tonsillitis, beginning in the deeper tissues, can seldom be checked, and the rapid formation of an abscess must be encouraged by inhalations of benzoin, hop, or conium, and the external application of poultices. Leeches do no good, unless at least six are applied. The abscess should be opened as early as possible with a bistoury, the greater portion of its edge being guarded by diachylon. The cut should be made inwards, and even before one is quite sure of fluctuation, since spontaneous rupture of the abscess is not free from danger.

In removing enlarged tonsils the guillotine is better than the knife. The instrument should be pressed firmly over the tonsil, which is supported by firm pressure from without. Hemorrhage is rare and is controlled by ordering the patient to slowly *swallow* tannic acid two parts, gallic acid one part, dissolved in a little water.—*Edinburgh Med. Jour.*, Jan., 1889.

Delavan (D. B.) on a New Instrument for Removal of Adenoid Hypertrophy in the Pharynx.—An unusually large hypertrophy, removed from the pharyngeal vault of a child five years of age, was presented at a recent meeting of the N. Y. Clinical Society. The instrument used is a combination of Mackenzie's and Major's modifications of Loewenberg's forceps. The blades are triangular and cut antero-posteriorly. The instrument is held like the Mackenzie amygdalotome, and the anterior blade is pushed down by means of the thumb. It seems to be especially applicable to growths of considerable size, lying principally in the vault of the pharynx.—*N. Y. Med. Jour.*, Jan. 26, 1889.

Levis (R. J.) an the Arrest of Hemorrhage Following Excision of the Tonsil.—This short article contains several sensible suggestions. The author refers to a single case of dangerous hemorrhage which he has seen, in which "an unnecessary entire removal of the tonsil had been effected by the form of guillotine that draws out the mass before the cut is made."

He properly speaks of Monsel's solution as follows: "the vilest of the abominations called styptics—a class of remedies which declare the inefficiency of the surgeon, and have caused more hemorrhage by masking its source and by loss of time, than they ever arrested."

In the case described, bleeding was instantly arrested by passing a tenaculum through the tissues at the base of the tonsil, giving the instrument a decided twist, closing the patient's jaws on the protruding handle, and passing a firm bandage about the head from chin to vertex. No hemorrhage followed removal of the tenaculum after twelve hours.—*Med. News*, Phila., vol. liii., p. 640.

Chappell (W. F.) on Examination of the Throat and Nose of Two Thousand Children to Determine the Frequency of Certain Abnormal Conditions.—In the entire number the following abnormal conditions were found:

Adenoid growths	60
Enlarged tonsils	270
Deviated septa	330
Spurs on septa	150
Hypertrophy of inferior turbinated bodies	260
Hypertrophy of middle turbinated bodies	161

This shows that 1,231 were suffering from some anatomical abnormality, and usually with its accompanying symptoms of respiratory obstruction and catarrh. Enlarged tonsils and adenoid growths are the only anatomical abnormalities that could be classed as belonging to very early life. The other abnormal conditions are acquired, usually after the age of six years, increasing rapidly with each succeeding year until puberty. All social classes are liable to them at about equal proportions, and at the same age. Males suffer more frequently than females, probably owing to greater exposure to the causes which produce catarrhal congestion and inflammation.

The increased number after six years seems to be due to several causes: (1). The greater frequency after that age of diseases prone to lead to inflammatory conditions of the throat and nose; (2) the more frequent occurrence of injuries of various kinds to which the nose is especially liable; (3) climate; (4) hypertrophied tonsils and nasal obstruction, which are doubtless causes of catarrhal conditions.—*Am. Jour. Med. Sci.*, Feb., 1889.

Bleyer (J. M.) on Some Practical Hints in Connection with Intubation of the Larynx.—The importance is

urged of making a laryngeal examination previous to intubating. It is claimed that thus we may avoid pushing membrane down before the tube, the extent of the lesion may be determined, and other diseases may be discovered. Forced laryngoscopy may be necessary. The method of accomplishing this feat in a child under five years of age is described. The author's "tongue tractor" seems to be an essential instrument. It is the custom of the writer of the paper to withdraw the tube daily, irrigate the posterior nares, pharynx, and larynx with a solution of bicarbonate of sodium, half an ounce to fourteen ounces of lukewarm water, and after the patient has expelled what debris may be present, permit the giving of food. The tube will often be found to be unnecessary after the second or third day. The usual signs of the presence of the tube in the larynx or œsophagus are given. In selecting a tube for a given case, one larger than the age of the patient indicates is usually demanded. Irrigations of the nostrils, of the mouth, pharynx, and larynx, with solutions of peroxide of hydrogen, are highly recommended (four to eight drachms of a fifteen-volume solution to twelve ounces of water). Internally glycozone is given, a quarter of a teaspoonful to a child over two years of age, and twenty drops well diluted to one under two years, every two hours. The paper closes with a résumé of 206 cases of intubation, with 67 recoveries.—*N. Y. Med. Jour.*, Feb. 2, 1889.

Hailes (W.) on Thirty-five Cases of Croup Treated by Intubation of the Larynx.—Eleven of these cases recovered, and several were hopeless when the operation was done. Some of them illustrate points of interest, one in particular offering great difficulty in extracting the tube.—*Albany Med. Annals*, Dec., 1888.

Holden (Edgar) on a Possible Substitute for Tracheotomy and Intubation in Certain Cases.—The author describes a bivalve instrument intended for introduction through the crico-thyroid space and upwards between the cords. The following advantages are enumerated: the danger of hemorrhage, erysipelas, ulceration, and sepsis, would be lessened; apnœa during introduction, interference with deglutition and so with nourishment, occlusion by membrane or by its being pushed downward, tracheal ulceration, aspiration of retained secretions, and inflammation from passage of food into the trachea, would be avoided; and expulsion by coughing, swallowing the instrument, or forcing it downward into the trachea would be impossible.

The "certain cases" alluded to in the title of this paper would at least be any where immediate and rapid operation for relief is demanded.—*N. Y. Med. Jour.*, Dec. 15, 1888.

Kayser on a Case of Laryngeal Carcinoma; Extirpation of Half the Larynx; Death.—The patient was a man, 35 years old, in whom hoarseness had been a prominent symptom for seven or eight months, when tracheotomy was done to relieve an attack of asphyxia. This diagnosis was based upon thickening, redness, and immobility of the right vocal cord, and the presence of a tumor in the right subglottic region, which was not influenced by antisyphilitic treatment. A piece of the tumor was removed by Gottstein and pronounced a sarcoma. The larynx was extirpated by Riegner, the operation being quite prolonged. Eight days later the first ring of the trachea was removed, and two days afterwards the patient died of cardiac paralysis.—*Deutsche med. Wchnschr.*, No. 45, 1888.

French (Thomas R.) on a Photographic Study of the Laryngeal Image during the Formation of the Registers in the Singing Voice.—The conclusions which may be drawn from this study are:

1. That protrusion of the tongue does not alter the laryngoscopic appearances.

2. That in the female voice there are three registers. This renders two changes necessary in the mechanism of the vocal bands. These changes are always accompanied by changes in the quality of the voice. The lower break occurs at or near F sharp, treble clef, first space; and the upper break at or near F sharp, treble clef, top line. The change of mechanism consists of a shortening of the vocal bands, an appearance of an increase in their tension, and a change in the shape of the chink of the glottis. The change in the mechanism is usually accompanied by a backward movement of the epiglottis.

The change in the shape of the chink at the lower break consists usually of a wider opening of the ligamentous portion of the glottis, and partial or complete closure of the cartilaginous portion of the glottis.

At the upper break the chink may simply be reduced in length and width, or a part of the ligamentous and all of the cartilaginous portion of the glottis may be closed.

3. That in male voices possessing the falsetto range there are two registers. The transition from the chest to the falsetto, usually occurs somewhere between C sharp bass clef, first line above staff, and the F sharp above.

The change in the mechanism consists usually of a sudden shortening of the vocal bands—though occasionally they are increased in length,—an appearance of increased tension, and an alteration in the shape of the glottic chink. The edges of the vocal bands may be brought into apposition in front or behind, or both in front and behind, or the chink of the glottis may be open in its entire length, in which case the shape is altered, but the area of the space between the vocal bands is about the same as is necessary for the production of the note before the break.

The falsetto tones are therefore produced by stop-closure and change in the length and tension of the vocal bands, or by change in the length and tension without stop-closure.—*N. Y. Med. Jour.*, Jan. 26, 1889.

Cohen (J. Solis) on Cantatory Paresis.—This is a form of impairment of the singing voice only, affecting a single portion of the register, or all tones above a certain part of the register. There may be no pathological change, or moderate congestion, or lack of tension of the vocal bands may be observed. It is usually a result of voice strain, occurring in a condition of impaired general health. It may be due to faulty respiration. The prognosis is good if attention be given to the case early enough. The first essential is rest of the singing voice and comparative rest of the conversational voice. Strychnine, quinine, and cocaine are the special medicinal agents most likely to be directly beneficial to the impaired muscles. Finally, systematic vocal exercises, limited to the unimpaired portion of the register, and daily percutaneous applications of currents of induction from one side of the larynx to the other will assist materially in overcoming the muscular atony, and thus hasten restoration of the vocal powers. Great care should be exercised in resuming prolonged vocal efforts for a year or two after apparent cure has been effected, lest the condition recur in an aggravated form.

In cases of moderate disability it is possible so to arrange the music as to avoid using the tones in which the voice shows impairment (Langmaid).—*Med. News*, Oct. 6, 1888.

Pye-Smith on Perichondritis of Larynx.—E. R., a mason, aged forty-eight, had had hoarseness for six months, and attacks of dyspnœa for four days. On laryngoscopic examination there was great swelling of the right ary-epiglottic fold, the cornicula laryngis being pushed to the left. Tracheotomy was performed, and in a fortnight the swelling had so much subsided that the tube was removed. The wound healed, and the patient breathed well for three or four weeks, when dyspnœa returned. Dropsy, with albuminuria, then appeared. Tracheotomy was again performed, but was rendered difficult by the scar tissue and the depth of the trachea (2½ inches from the surface), making a specially long tube necessary. The dropsy and nephritis continued, bronchitis followed, then right pleurisy, and, finally, pericarditis, proving fatal on the eighteenth day after the second operation. *Post-mortem* examination: Three ulcers were found in the larynx, one above and two below the right cord, all communicating with a cavity which laid bare part of the internal surface of the ossified cricoid cartilage. There was no history of syphilis. The kidneys, pericardium, and right pleura were inflamed.—*Brit. Med. Jour.*, Dec. 22, 1888.

Weinbaum on Electricity in Goitre.—Gold needles are passed for several millimetres into the tumor and a moderate galvanic current is used for fifteen minutes. An eschar may form at the negative pole. In one case one hundred and five, and in another fifty applications were required to disperse a tumor.—*Lyon Médical*, Sept., 1888.

Knight (F. I.) on a Case of Bronchial Asthma.—In reporting this case, Dr. Knight takes the opportunity to protest against the idea that bronchial asthma is a simple neurosis—a simple bronchial spasm in a perfectly healthy lung and tubes. Bronchial asthma is, as a rule, a complex manifestation requiring several factors, and although nervous irritability comes in as a predisposing element, we will often find, as in this case, that the manifestations do not begin until some morbid condition of the lung itself has been set up.

In the course of the discussion on the

paper, several interesting points were noticed, and the author drew attention to the prevalence in medical journals of cases of asthma due to *nasal obstruction*. So that one would almost think that the nose was always guilty in these cases. But this is not the truth. The exciting lesion may be in the lung, in the nose, or the stomach, or some other remote organ.—*Boston Med. and Surg. Jour.*, Jan. 17, 1889.

THERAPEUTICS.

Stewart (J. T.) on Hypodermic Injections of Ergot in Facial Neuralgia.—For the relief of facial neuralgia hypodermic injections of ergot are incomparably superior to aconite or gelsemium. Any one who has used it will never resort to either of the above-named remedies. I have used it the last six years and have never had it fail in but one case. In that case there was evidently organic disease. Ordinarily one injection relieves the pain permanently. Sometimes two, and in one very severe and obstinate case which had gone through the hands of several physicians without relief, it required three. After the third injection he never had a twinge of pain. I put it in the temple, as nearly over the seat of pain as convenient. I use the plain extract, and have it made on purpose for hypodermic use. One minim represents two grains of ergot. Of this I use from eight to twelve minims, blood-warm, at one injection, and without diluting.

In order to make this a success, two things are essential. One is, to have a fresh and pure article of ergot to make the extract from, and the other is, to have the extract reasonably fresh. If kept long, it is not only worthless, but irritating. When properly prepared and fresh, it produces more or less pain for ten or fifteen minutes, and when the pain from the injection subsides the neuralgia is usually gone, and does not return.

I have used this treatment for sciatica and other forms of neuralgia, but not with very satisfactory results.—*Peoria Med. Mo.*, Jan., 1889.

Pugh (W. W.) on Traumatic Tetanus cured by 100-Grain Doses of Sulphate of Quinia.—I was called, December 17th, to see a man suffering with tetanic spasms. A splinter had been stuck in his thumb some three or four days previous. I at once administered one hundred grains of the sulphate of quinine with Norwood's tincture, gtts. six, and in twenty-five minutes he was sleeping and rested well for three hours. I repeated the dose in eight hours, then every eight hours afterwards, reducing the dose twenty grains. The convulsions left him entirely in twenty-four hours, and on the sixth day he was up and rode to my office to see me.—*So. Practitioner*, Feb., 1889.

Emerson (J. E.) on the Indiscriminate Use of the Bromides in Disorders of the Nervous System.—After narrating a case of extreme nervous prostration, with great weakness and delirium, in which the bromides did harm and strychnia and salicin much good, the author says:

"Think twice before administering the bromides, especially if you have any doubt as to the nature of the pathological conditions causing the nervous disturbance.

"Remember that the bromides act powerfully on the vaso-motor nerves and diminish the blood supply to the capillary vessels of the brain and cord, and possibly of the muscles and cutaneous tissues. Ask yourself the question, whether you wish to diminish the functional activity of the brain and cord by diminishing their blood supply, or whether the over-activity you wish to allay may not be due to a diminution of vaso-motor control, which other remedies will better correct."—*Am. Lancet*, Feb., 1889.

Bromine as a Deodorant.—Mr. Martin the chemist of the Health Department of this city, has suggested its use upon the earth thrown up in laying the electric subways. It has the property of precipitating the hydrocarbons of illuminating gas, and thus can be used to deodorize the earth exposed in excavations in the vicinity of gas-mains. More valuable than this is its effect upon decomposing organic bodies, which it renders completely inoffensive. This property renders it particularly valuable for use in stables, privy-vaults, urinals, cess-pools, or in any place which may contain foul-smelling organic matters. It is soluble in about thirty-three parts of water, but a solution of this strength is not advisable, as there is a constant escape from it of the vapor of bromine, which is very irritating to the eyes and air-passages, and which may even attack wood and metals. For ordinary purposes, it is used in solutions containing

one part by weight to about eight hundred of water. In this strength it may be used freely without its affecting any thing which it may touch. A few gallons used daily will remove all ammoniacal odors from stables, or a few quarts will thoroughly deodorize the entire plumbing system of an ordinary house. It also might be used with advantage upon ordinary house garbage, which usually becomes offensive so speedily in warm weather. The only drawback in its use lies in the fact that the undiluted bromine is strongly corrosive, and, if it touches the skin, causes a painful burn. Where it is used in large quantities this can be obviated by opening the bottle or, what is simpler, breaking it under water. As its use becomes more extended it will undoubtedly be put up in pearls or tubes containing only as much as would be needed at one time in the average household.—*N. Y. Med. Jour.*, Feb. 2, 1889.

Russell (J. P.) on Germicide Soaps.—Of the numerous forms in which antiseptics have been placed upon the market, possibly the so-called antiseptic soap has been the most successful.

In order to form a just and impartial opinion of the antiseptic properties of these much-vaunted soaps the writer concluded to test their powers in checking or preventing putrefaction.

For this purpose he prepared a culture-fluid of beef-broth and egg albumen, in which putrefaction had taken place, the fluid containing myriads of bacteria.

The soap tested consisted of the following:

No. 1. Fels' Germicide Soap.
" 2. Seabury's Hydronaphthol Soap, 1 per cent.
" 3. Packer's Pine Tar Soap.
" 4. Oakley's Carbolic "
" 5. Calvert's " "
" 6. Graham's " "
" 7. Graham's Sulphur "
" 8. Chlorine "
" 9. Glenn's Sulphur "
" 10. Venus "
" 11. Cuticura "
" 12. Althene "
" 13. Potassio-Mercuric Iodide Soap, 2 per cent.
" 14. Ammonia Ichthyolate Soap, 10 per cent.

In order to fairly test the actual value of these soaps, when used as they are intended to be, after various experiments a three-per-cent. solution was chosen as being probably the closest approximation of strength to that which we get in the act of lavation.

The various soap solutions were put with an equal quantity of the culture-fluid, in test tubes, which were then plugged with antiseptic cotton, and all placed under like conditions at a temperature of 65° F. to stand for 8, 12, 24, 36, and 48 hours. At the expiration of each of the designated periods, they were carefully examined under the microscope.

At the expiration of eight hours all signs of micro-organic life had disappeared from No. 13. As none of the other solutions gave any signs of change before 46 to 49 hours, we will only speak of their condition as shown at these periods.

Nos. 1 and 2 contained all the forms of micro-organic life as seen in the culture-fluid to which no soap had been added. No. 3 showed vibrio and comma-shaped bacillus in large numbers, but no rods. No. 4 was the same as No. 3. Nos. 6, 7, 8, and 10 showed the same condition as Nos. 1 and 2.

Nos. 9 and 11 showed a few vibriones and comma bacilli, but their movements were slow. No. 12: a few vibriones could be here seen, but they were quite sluggish in their movements.

No. 13 gave no visible signs of life. No. 14 was full of vibriones and comma bacilli.

As the microbe had come off conqueror in the contest, we thought it but justice to the soaps to give them a chance to regain their lost prestige.

In the above experiment the soaps had been thrown on the enemy when the latter was in full life and vigor. In the second contest the soaps were brought against their adversaries while the latter were yet in an embryonic condition. To a freshly prepared culture-fluid there was immediately added a three-per-cent. solution of the soaps, and this was allowed to stand in cotton-stopped test tubes. To another test tube containing culture-fluid was added a solution of potassio-mercuric iodide (1–1000), and one tube containing the culture-fluid alone was reserved for comparison.

At the expiration of twenty hours, the culture-fluid contained micro-organisms plentifully, and was quite offensive in odor.

The fluid to which the potassio-mercuric iodide had been added showed a few vibriones and comma bacilli, but was free from odor.

The soap solutions were as follows: Nos. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 showed micro-organisms in abundance, with quite rapid movements; No. 12 showed a few comma bacilli, with slow movements; No. 14 presented about the same appearance as No. 12; while No. 13 gave no visible signs of life; Nos. 1, 2, 3, 5, 8, 11, 12, 13, and 14 gave no odor of putrefaction; all the others were quite offensive. Now, as to the deodorizing properties of the various soaps: some of them were highly perfumed, greatly masking the odor of putrefaction, so that recognition of this condition became difficult.

As deodorizers they stand as follows: Nos. 1 and 2 very little odor, highly perfumed; Nos. 3, 4, 6, 7, 8, and 9 were quite offensive; No. 10 slight odor of putrefaction. In Nos. 11 and 12 no odor of putrefaction was perceptible; No. 13 was entirely free from odor; No. 14, very slight smell of putrefaction, the odor of ichthol predominating.

Noticing that No. 5, Calvert's carbolic soap, deodorized the solution, while none of the other carbolic soaps did so, we were led to look for the cause. Noting that this soap was colored red, and believing that it owed its deodorizing power to the coloring matter, on examination we found that the latter consisted of vermilion or red sulphide of mercury, of which the soap contained about ten per cent. To prove that this was the deodorant, a sample of the soap was dissolved in alcohol, and the vermilion filtered out, the alcohol was evaporated off, and the soap dissolved in water and added to a putrid culture-fluid; this failed to deodorize, showing that the soap depended on the mercurial salt for its deodorizing power.

There was no chemical examination made of any of the samples other than that stated above, excepting that they were all tested for alkali. All proved to be alkaline with the exception of Nos. 12, 13, and 14.

Samples Nos. 13 and 14 were made by the writer by taking olive oil soap, adding to it two to three per cent. of oleic acid, heating and then incorporating the medicament.

In justice to the manufacturers of some of these soaps, it must be admitted that they make no claim for their soaps of antiseptic or germicidal properties, merely stating that they contain carbolic acid, sulphur, or other medical agents; whilst others make the most preposterous claims for their goods as specifics for all forms of eruptive disease.

Why physicians should designate a certain make of medicated soap for their patients, when by the exercise of a little thought, they could formulate what they wish them to have, and any good druggist would be able to make it, we cannot conceive.

No. 12, which does not make a pretence of medication or of antiseptic power, basing its claim for superiority solely upon its purity as a soap, has yet proven in these experiments to be the best of the proprietary soaps examined. It is the best base for physicians to use in formulating medicated soaps, as it was the only soap which proved to be absolutely neutral in reaction; this fact we attribute to its deodorant and aseptic properties, as alkaline solutions favor decomposition.

From the data here presented, we think that it is clear that the so-called antiseptic soaps of the market are far from being antiseptic. In point of fact, the very reverse holds good; and it seems the best way for the physician who desires a really antiseptic soap, is to do what has previously been recommended, namely, to formulate his own, using some good *neutral* soap as the base, and medicating with whatever remedy and in whatever quantity he may desire. In this way, and in this way only, apparently, can he be certain of the results that he desires to achieve.—*Med. Times*, Jan. 15, 1889.

Trott (G. A.) on Digitalis in Remittent Fever.—Two years ago I began to notice that when, from cardiac weakness or other causes, I had occasion to use digitalis with any regularity the unfavorable symptoms decreased steadily after thirty-six hours and the fever terminated in a few days. Continuing my investigations I discovered that the fluctuations of the febrile movement were greatly lessened under the influence of this drug, and have seldom noticed a greater variation than two degrees in twenty-four hours. I became so thoroughly convinced of the utility of the drug that during the year 1888 I resorted to digitalis on the first appearance of typhoid symptoms, with the uniform result

of entire subsidence of fever in five days from commencing the digitalis. I treated sixty-nine cases of true typhoid and typho-malarial cases without the loss of a single patient, and, as a rule, the fever subsided on the fifth day of treatment with digitalis. —*Med. Age*, Jan. 25, 1889.

Is Apomorphine a Safe Emetic?—An anonymous correspondent writes: Some few months back, a woman was brought to me in a maniacal state by a policeman, who told me that, having had a "few words with her husband," the patient drank off the contents of a bottle of liniment. The bottle, which he brought with him, contained eleven drachms of lin. camph. co., and as it was said to have been more than half full, and was a pint wine bottle, I concluded she had swallowed at least five ounces. Failing in my attempts to administer an emetic, and fifteen minutes not having elapsed since the occurrence, I injected subcutaneously one-fifteenth of a grain of apomorphine. In a few minutes the woman became quiet, and then rapidly collapsed, and despite the injection of brandy and ether, the application of hot bottles, etc., died twelve minutes after the injection.

A post mortem was refused. Having some suspicion as to the apomorphine, I had the solution I used analyzed, and was informed that in all respects it was good. The patient vomited only two ounces of the liniment swallowed, and that while I was giving the injection, and I am compelled to think that the death was due to the apomorphine.—*Brit. Med. Jour.*, Jan. 19, 1889.

Thomas (J. H.) on a Case of Ecezma Partly Cured by Vaccination.—In November, 1884, a child was brought under my care with eczema. The child was covered with it from head to foot. It was the very worst case I had ever seen. I treated the child in the usual way for about six months, but with no benefit. I then advised vaccination. This the parents refused, stating that the vaccination officer had repeatedly postponed the vaccination. From this time I lost sight of the child for about two years, when the mother again brought her to me. I found the child in the same state, one mass of eczema. I again advised vaccination.

I procured some calf lymph and vaccinated in the usual way in four places. At the end of a fortnight there was a slight improvement, and now (three months after) there is a decided and marked improvement. The face is quite clear, and the body generally, except some patches on the head, the back, and the backs of the knees. After the vaccination I told the mother to keep the child as clean as possible, but no treatment of any kind was used. There was no history of syphilis in the case.

I do not mean to say that vaccination is a cure for eczema; but I consider in a case of inveterate eczema it is worth a trial. —*Brit. Med. Jour.*, Jan. 19, 1889.

A Remedy for Pediculi Pubis.—The treatment of pediculi pubis by the usual blue ointment has so many inconveniences, with its disagreeable application and its toxic after-effects, that the use of the well-known antiparasitic action of salicylic acid has of late been much extolled. The formula given is:

℞	Salicylic acid . . .	2 to 3 parts.
	Toilet vinegar . . .	25 parts.
	Alcohol (80 per cent.),	75 parts.

The parts are to be rubbed with a piece of flannel wet with the mixture. In most cases a single application will be enough to destroy the pediculi.—*Med. Press*, Jan. 9, 1889.

MEDICINE AND PATHOLOGY.

Wheeler (W. J.) on Syphilitic Deposits in the Human Tongue, Followed by Epithelioma.[1]—A man æt. 48, had served for twenty-one years in a foot regiment, and in the eleventh year of his service was unfortunate enough to contract syphilis, which was followed by an ulcerated throat, an eruption over the front and back of his chest, and some periosteal inflammation over his left tibia. Shortly after the partial subsidence of those symptoms a circumscribed swelling appeared on the left side of his tongue, rather towards the posterior part. For the above-named affections he was treated with mercury and iodide of potassium. The eruption disappeared, the periostitis yielded to this treatment, as also did the swelling on his tongue, but it never completely disappeared.

Three years after he had contracted syphilis the swelling of his tongue increased.

[1] See MEDICAL ANALECTIC, 1888, pp. 203, 337.

Mercury and potash were administered and again the enlargement reduced. On four subsequent and different occasions he was similarly treated, and on each occasion there was a marked diminution of this swelling until the last occasion, a year before he retired from the service. On his admission into the hospital the growth as alluded to could be both seen and felt hard and firm at its edges, and having a granulating appearance on parts of its surface.

On account of his previous history it at first appeared that it was only syphilitic, but on closer examination I observed some small granular masses, which are unusual in purely syphilitic ulceration (although sometimes occurring), I therefore determined to excise it. Another reason that induced me to operate immediately was the fact that my experience has taught me that old syphilitic deposits are fertile sources of cancerous development.

Microscopic sections of this case of epithelioma, exhibit a well marked inflammatory process beneath the epitheliomatous growth, which does not extend far into the muscular structure of the tongue.

Similar observations have led me to operate early in all persistent growths or deposits in the tongue, which I have shown to be prone to develop into cancer, and consequently are better removed in what in my opinion has been correctly termed the pre-cancerous stage.—*Med. Press*, Jan. 23, 1889.

Dana (C. L.) on Chronic Headache.—The author's study was based on a study of two hundred cases of chronic headache functional in character, excluding migraine. His conclusions were: 1. There should be more general recognition and differentiation of chronic head pains of functional origin. 2. Pains in the head are either neuralgias, migraines, or so-called headaches. 3. The seat of headaches is always in or referred to the trigeminal, vagus, or four upper cervical nerves. 4. Headaches are seated in or referred to the periphery of the nerves in question; neuralgia is seated in the trunks or central; migraine is a periodical discharging neurosis, affecting motor, vaso-motor, secretory, as well as one or more cranial sensory nerves. 5. The dura mater is the most frequent seat of headache. 6. The great headache ages are from eight to twenty-five, and again from thirty-five to forty-five; childhood and old age are exempt. 7. The chronic functional, non-migrainous headaches may be classified as hæmic, including diathetic forms, toxic, dyspeptic, neurotic, reflex.

More exact knowledge of the nature of headaches may be gathered by studying the location and character of the pain in its relation to cause. Neurotic headache is best treated symptomatically by antipyrin, menthol, antifebrin, caffein, and bromides. Headaches due to reflexes are often treated better constitutionally than by means directed to local conditions. Rheumatic headaches were best treated by ammonia, chloral, and warmth.—*Med. Record*, Feb. 9, 1889.

Holt (L. E.) on the Prevention of Summer Diarrhœa among Infants Viewed in the Light of the Lesions.—The paper dealt with lesions amounting to an entero-colitis commonly found in feeble children after dyspeptic catarrh and diarrhœa had existed for a short time. Autopsies had shown in nineteen out of fifty-seven cases enlargement of the solitary follicles, with softening at their summits, which soon resulted in a large number of small round ulcers. It was thus an affection of the lymphoid elements in the intestinal tract. The dyspepsia which caused the beginning of this change often came with teething. As these ulcers never healed, so far as he had discovered, and went on to the death of the child, preventive treatment was of the utmost importance, and to this end milk free from the germs of fermentation must be secured and care exercised to prevent the almost invariable overfeeding of infants which was customary in all classes of society. Loose movements continued for any length of time were never a physiological relief, but represented the beginning of a fatal process. *N. Y. Med. Jour.*, Feb. 9, 1889.

Thompson (W. H.) on the Significance of Cough and the Use of Expectorants.—The writer reviews the various coughs and the rational means of relieving each according to its cause, sometimes by small opiates, at other times by demulcents, and at others by expectorant drugs. He spoke of the hacking cough of pleurisy, its meanings, and its relief by strapping that side of the chest so as to secure rest. This done for a pleuritic cough in the beginning of phthisis much delayed the development of the latter. The cough of pertussis could be stoppped in a week's time by full doses of belladonna

(sometimes with the addition of a little chloral), although the disease went on to the end of its course.

When a cough of the expectorating variety was difficult on account of the viscidity of the phlegm, the administration of an oil greatly lessened this difficulty by causing liquefaction of the secretions. The best oil for this purpose, although unmentioned in most text-books, was the raw linseed-oil given in an emulsion. It was also an excellent substitute for cod-liver oil, when this could not be borne, in phithisis. It relieved bronchial asthma and asthma in those much affected by changes in weather; also congestive bronchitis, the bronchitis of heart disease, and senile bronchitis. He recommended the following formula:

Linseed-oil		℥ xv.
Oil of wintergreen, Oil of cinnamon,	āā	ʒ ij.
Glycerin		℥ v.
Simple syrup		℥ x.
Water		℥ xxiv.

—made into an emulsion. Dilute hydrocyanic acid (ʒ iiss.), Magendie's solution (♏xl.), or chloral (ʒ iss.) might be added in suitable cases.—*N. Y. Med. Jour.*, Feb. 9, 1889.

Williams (W. R.) on the Duration of Life in Cancer of the Breast.—Considerable discrepancies are apparent in the results arrived at by different investigators of this important subject. Astley Cooper says: "The progress of this complaint is in some persons extremely slow. In general, however, it destroys life in about four years from the commencement." Paget finds that "the average duration of life, from the patient's first observation of the disease, is a little more than four years." Bryant's experience agrees with this. According to Sibley, the duration of life in cases *operated on* is 53.2 months; and in those *not operated on* 32.25 months. Gross, the latest worker in this field, gives 38.5 months as the duration of life for those operated on; and 28.6 months for those in whom the disease ran its course without any operative interference. I have recorded and tabulated all the fatal cases of breast cancer under treatment at the Middlesex Hospital during the last six years, with the result that the average duration of life—dating from the time when the disease was *first noticed*—is 60.8 months for those who underwent operation, and 44.8 months for those in whom the disease ran its natural course. Gross' statistics are derived from massing the results of more than a dozen different surgeons, chiefly German. He has not expressly stated that in all his cases the duration of life is dated from the time when the disease was *first noticed* by the patient. It appears to me, whether from this cause or some other, that his figures considerably under-estimate the total duration of life in this disease. I believe the experience of English surgeons will be found to be more in accord with my figures.

I will now give, as briefly as possible, some further information on this subject. I think the facts revealed justify us in taking a more hopeful view of breast cancer than is customary. We must not forget that cancer is a disease less malignant in some parts than in others. The prognosis is certainly much better in breast cancer, as regards duration of life, than it is when this disease affects the tongue (18 months), the uterus (24 months), or the rectum (27 months). In this respect cancer of the breast is on a par with cancer of the lower lip, in which the average duration of life is 60.7 months. In the following estimate a month means 28 days.

1. The duration of life in 64 fatal cases, dating from the time when the disease was *first noticed*, was 52.8 months. Of 4 cases operated upon in which the duration of the disease exceeded 102 months, it lasted 137.6, 149.8, 159, and 297 months respectively. Of 4 cases not operated upon in which the duration of the disease exceeded 102 months, it lasted 116.6, 130, 157, and 194.7 months respectively.

2. In 25 cases the *average* duration of life subsequent to amputation of the breast, etc., for the primary disease was 40.3 months; the shortest, 7 days; the longest, 259 months.

3. The average interval between the first operation and the first obvious recurrence (in 46 cases) was 26 months; the maximum, 130 months; the minimum, 2.5 months. The duration of the interval between the first operation and the first obvious recurrence in the 8 cases of from 52 months and upwards was as follows: 52 months (2 cases), 58, 62, 89, 91, 124, and 130 months respectively.—*Lancet*, Jan. 12, 1889.

Williams (G. O.) on a Novel Method of Intubation with Ordinary Rubber Tube.—Quite a number

of fatal cases of diphtheria die in consequence of the obstruction to respiration caused by the closure of the fauces from tumefaction of the tonsils and uvula, the larynx at the same time being intact. The majority of those which fail within the first forty-eight hours are from this cause.

The case in question was of this character. The disease had existed forty hours. The child's age, eleven years. The fauces and soft palate were covered with exudation. The throat was closed. Respiration very labored. Constant restlessness had been present for thirty-six hours. All the indications of slow suffocation were present. The child was informed of what we desired to accomplish, and his promise to assist as much as possible was secured.

A soft rubber tube was then passed beyond the obstruction, and its extremity left just at the larynx. The boy nodded his head to indicate that it gave him relief and was in proper position. Within three minutes he dropped into a motionless slumber of absolute rest. The distressing breathing was instantly relieved.

The sleep continued an hour. At the end of that time a little mucus obstructed the tube, and he awoke and pulled the tube from its place. It was immediately replaced. The tube extended six inches from the mouth. An attendant constantly supported this extremity. An ink mark on it, on a line with the teeth, designated the proper distance for introduction. After a few hours the care of the tube was intrusted to the friends. It was maintained in use for seventy hours. It was removed for cleansing, and for nutrition and medication at proper intervals. At the end of that time the subsidence of the tumefaction permitted its discontinuance. The tube measured seven eighths of an inch externally. No complication occurred in the case and a good recovery followed. I do not recall any published account of such a procedure in diphtheritic cases, but I think quite likely, from its simplicity and efficiency, that it must have been in use by others.—*Med. Record*, Jan. 26, 1889.

Munk (E.) on Massage in Sprains.—The author's treatment is illustrated by the following directions for treating a sprained ankle. He begins with gentle centripetal friction, commencing at the toes and gradually proceeding upwards as far as the painful spasm reaches, using first the finger-tips, then the whole surface of the hands. As the pain disappears, more and more force may be applied, and when the contraction has so far relaxed as to leave the joint movable, gentle passive flexion, extension, and rotation should be performed. After one or two sittings the movement of the joint will be quite free and almost painless. More and more force may now be applied and active and resistive movements added. The treatment ought to be repeated two or three times daily; and provided there is no fracture, four to ten days are enough to give complete cure. The sooner the treatment is begun the better, and plaster of Paris ought to be avoided altogether.

In sprains of hips and shoulders longer time is required, but the same favorable results are always attained.—*Pittsburgh Med. Rev.*, Jan., 1889.

Stimson (L. A.) on Giant-Celled Sarcoma of the Astragalus; Excision of the Bone.—A man of twenty-five gave a history of pain and sensitiveness in the foot of eighteen months' standing. The dorsum of the foot was the seat of general swelling. On making longitudinal incision along the antero-external aspect of the leg and foot, the ankle-joint was opened and the tumor found in the head and neck of the astragalus. The entire bone was removed. The other bones presented a normal appearance. The patient made a rapid recovery and had been walking about for over a month. There was slight motion at the ankle-joint. On microscopical examination of the growth, it proved to be a giant-celled sarcoma. The reporter had removed the astragalus in five cases during the summer, a fairly good functional result being obtained in each case.—*N. Y. Med. Jour.*, Jan. 26, 1889.

Is Instrumental Delivery a Cause of Idiocy?—Drs. Winkler and Bollaan mention[1] a case of bilateral, almost symmetrical, damage to the cortex of the brain, found in an idiot. The boy had been born with the aid of forceps. Only part of the vertex could be examined. There were no marks of the forceps, yet there were strong reasons for belief that the injury was caused by them. In another case there was still more ground for the opinion that injury had been caused by forceps. In this child, who was an idiot from birth, there were marks of the forceps

[1] Quoted in *Lancet*, Jan. 5, 1889.

on both sides of the skull corresponding almost exactly to the damage done to the brain. This coincidence was too remarkable to be accidental. Drs. Winkler and Bollaan performed necropsies on ten idiots, and examined twenty-five living idiots, of whom six had bilateral depressions in the skull. Another case was that of a woman born with the aid of forceps. She was very short, being only 1.27 metre high, and small in proportion. She could make all movements, isolated movements being difficult to her. There were but two words which she could say, and she never gave any sign of understanding what was said to her. She died at the age of sixty, and at the necropsy the brain was found to be very small, weighing only 742 grammes. All the organs at the base of the brain, the optic nerves, olfactory nerves, etc., were found to be very small. Deep depressions were found on either side of the sagittal suture, the right side being the more indented. The depth of the depression was two millimetres, and its greatest breadth twelve millimetres. The brain was much atrophied. The authors believe that depressions of the skull caused by instrumental delivery, even when no fracture occurs, tend to damage the cortical substance of the brain, and that this leads to general atrophy of the hemispheres, thus producing idiocy. They are disposed to think that the use of forceps is much more frequently the origin of idiocy than is generally supposed.

Dr. Fletcher Beach writes to the *Lancet*, Jan. 12, 1889: "The researches of those of us who are engaged in the training and treatment of idiots and imbeciles prove that the use of the forceps has much less influence than their disuse in the production of idiocy and imbecility. I have for some years taught the students, who are sent here by some of the lecturers on psychological medicine, that prolonged and difficult labor is a potent cause of imbecility, and that in such conditions it is better to put on the forceps than to run the risk of prolonged compression of the head, resulting in asphyxia, paralysis, and other evils. Of course, one supposes that the forceps will be put on carefully. I have lately been inquiring into this very subject, and, putting aside the predisposing causes of intemperance, insanity, imbecility, epilepsy, etc., which are often present, I find that of 810 cases, in which I have been able to obtain histories, only thirty-five, or 4.3 per cent., are said to be due to the application of forceps, while 216, or 26.6 per cent., are due to prolonged and difficult labor. Further, the majority of these cases, when born, were not only asphyxiated, but were in a helpless condition, some having lost the use of their legs, others becoming subject to convulsions. Moreover, the head was often crushed, elongated, discolored, and deformed. On the other hand, in the thirty-five cases which had been delivered by forceps, only seven were helpless or paralyzed. I therefore maintain that the use of the forceps is preferable to prolonged and difficult labor, and I would ask the profession not to be misled by the few cases of Drs. Winkler and Bollaan."

Dr. J. L. Down writes to the *Lancet*, Jan. 19, 1880: "I find, from an examination of all my cases of idiocy about which positive information could be obtained, that in only 3 per cent. were the forceps employed. In every case, however, where they had been employed, the friends of the child believed that the instrument alone was the cause of the disaster, while in nearly every case I could discover quite sufficient to account for the mental defect in the neurotic history of the progenitors. In a very few cases, only a small fractional percentage, could I arrive at the conclusion that the use of the forceps was the principal cause of the calamity. I find in a very large number of my cases that the labor was stated to be unusually tedious and prolonged. Dr. Playfair has shown that the employment of the forceps does not interfere with the viability of the offspring; and that a prolonged labor is more compromising to the life prospects of the child than a judicious and timely application of the forceps. When it is borne in mind how frequent is the association of suspended animation with idiocy, it cannot, I think, be too strongly enforced that the mental integrity of the child is more likely to be compromised by a prolonged pressure in the maternal passages than by skilled employment of artificial assistance. The accoucheur who postpones instrumental help often does so at the risk of terrible consequences to the nervous system of the little one he is solicitous to protect. In my somewhat recent Lettsomian lectures delivered before the Medical Society of London I was able to confirm by additional experience that which I had so strongly enforced before."

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRUGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLES.

STONE IN CHILDREN.

Dr. Keegan [1] of Central India, in a paper read before the American Association of Genito-Urinary Surgeons, gave his recent experience in litholapaxy in male children. He presents an unbroken series of one hundred and fourteen litholapaxies performed on male children and boys at the Indore Charitable Hospital, Central India. The author by his experience has satisfied himself that the calibre of the urethra in male children is, as a rule, much larger than surgeons in former days believed was the case. The average number of days spent in the hospital by these one hundred and fourteen patients after litholapaxy was 5.7, and the average weight of stones removed was 95.05 grains. The percentage of mortality was 3.5. The operator has shown that Bigelow's operation is capable of dealing successfully with any large and hard stones occurring in boys. He distinctly prefers the fully fenestrated lithotrites to those partially fenestrated and wholly unfenestrated. He regards the latter as absolutely dangerous in dealing with stones in male children. The advantages which litholapaxy possesses over its two rivals, suprapubic and lateral lithotomy, the author believes to be chiefly two—namely, rapidity of cure and avoidance of the dangers inseparable from all cutting operations. As to the recurrence of stone after litholapaxy, Dr. Keegan does not think that it recurs with any greater frequency after a well performed litholapaxy in boys than it does after suprapubic or lateral lithotomy.

Dr. Sandwith [2] an English surgeon in Cairo, reports a case of suprapubic lithotomy and speaks of five other cases which had been so operated on in the Kasr-el-Aini Hospital during the preceding twelve months. The author speaks of the very tender age at which children in Egypt become the possessors of calculi. He had recently removed from a boy of eighteen months, a calculus weighing 201 grains; and from a boy of six, a stone of 162 grains. In this latter case, he says that the wound was healed on the 20th day and the child sent home. The writer observes that the favorite operation for stone among native surgeons is lateral or median lithotomy, but that English surgeons, especially those in the Egyptian Army, prefer lithotrity.

Dr. A. B. Strong of Chicago,[3] presents the histories of seventeen cases of calculi in children, with some considerations on the etiology of the condition. Of these seventeen children, two were of German parentage, while fifteen were of Polish origin. The author calls attention to the well-known facts that in about 95 per cent. of all urinary calculi the nucleus is uric acid; that stone is more frequent in childhood than in adult life; and that infantile urine is always concentrated and heavily charged with urates. The writer seeks for some

[1] *N. Y. Med. Jour.*, Sept. 22, 1888.

[2] *Lancet*, Sept. 29, 1888.

[3] *Peoria Medical Monthly*, July, 1888.

condition in the life of these Polish children which may account for their special liability. He finds a custom almost universal among this people, that seems to him to be at least one factor in the causation of the disease. He refers to the meat diet given to the little children. As a rule the child is weaned at ten or twelve months, and then begins his independent existence by living largely upon sausage, an article of diet cheap, easily prepared, and very nutritious. Carpenter is quoted as saying: "On a full meat diet the normal daily excretion of ten grains of uric acid is increased to thirty-two and five-tenths grains." In the case at least of his Polish patients, Dr. Strong feels that the meat diet was an important etiological factor.

Dr. J. H. Fruitnight[1] discusses at some length the subject of "Urinary Concretions in Children." He speaks of the occasional apparent influence of heredity and family idiosyncrasy in the occurrence of this disorder, and quotes the report of a family of which six children all had stone. The father and mother both passed quantities of uric acid, the grandmother and grandfather, a great-uncle, six uncles, four aunts, and one cousin had either all had attacks of gravel or had been cut for stone. Habit and nutrition play quite a prominent part in the causation of lithiasis. Habit is more important in adult life than in children. Poor nutrition favors lateritious deposits because of the abnormal composition of the urine. The activity of the skin also counts as a factor. The same general intrinsic causes exist in the child as in the adult. The concretion may be deposited in some one of the urinary organs in consequence of some abnormality in the composition of the urine; there may be present an excessive proportion of precipitable ingredients in the urine; the urine may be too acid in reaction, thus diminishing its solvent power over uric acid and the urates; there may be ammoniacal decomposition of the urine in the lower urinary passages, favoring the precipitation of the earthy phosphates and carbonate of lime; acid fermentation in the presence of the mucous secretions of the urinary passages, is another cause of urinary concretions. Occasionally a catarrhal condition of the pelvis of the kidney in children occurs, which may lead to symptoms corresponding exactly to calculous pyelitis of later life. If this catarrh of the pelvis of the kidney lasts a long time, it may gradually spread to ureters and bladder, and so favor the development of vesical calculi. The presence of an abnormal substance of slight solubility in the urine, as cystine or xanthine, the accidental presence of a body suitable to become a nucleus of a calculus, and certain diatheses, rheumatic, gouty, or dartrous, exist as causes in children as in adults. The presence of renal infarctions in newly born infants is explained as the result of increased physiological tissue metamorphosis, which is induced after birth by the establishment of the processes of respiration, digestion, and calorification. Infarctions are rarest in those infants who die very soon after birth; more frequent in those children who have lived twenty-four hours, and most frequent in those who die between the second and fourteenth day after birth. Infarctions are met with in less than fifty per cent. of newly born infants, which proves that the conditions assuring their production must be inconstant.

The calculi most commonly met with in children are composed of uric acid or the urates. Those consisting of the urates, and especially of the urate of ammonia, are most frequently found in nurslings. Cystine concretions are very rare in children, xanthine and fibrine concretions have not been found, nor have phosphatic or carbonate-of-lime calculi.

The size of the concretions in children ranges from that of a pea to that of a good-sized marble. Quite large calculi are often met with in very young female children.

Though the uric-acid infarcts, which are so frequently present in the newly born, are usually washed away more or less speedily in the first month or two of life, some of the detritus may remain in the tubules and pelves of the kidneys. Infants undoubtedly suffer from nephritic colic as well as adults, though such a diagnosis is seldom made. The little patient suffering from urolithiasis will strain in its efforts to pass its water. There is intermittent urination accompanied by pain. Attacks, constantly recurring, of violent and apparently inexplicable screaming spells in a young child, frequently depend upon the presence and elimination of gravel and renal calculi. In very young children the napkin on examination will exhibit dark-reddish or yellowish stains,

[1] *N. Y. Med. Record*, Feb. 2, 1889.

and occasionally gravelly crumbs can be felt. This brown dust is said to be found oftener on the napkins of the puny infant than on those of the robust. The burning caused by the hyperacidity of the urine is felt not only in the urethra, but also at the meatus, the glans, and the labia. In older children the concretions are of newly formed rather than of infarcted uric acid. The author reports a number of cases from his practice to illustrate the symptoms of urolithiasis at the various ages.

It is very likely, in the opinion of the writer, that often when intestinal colic has been diagnosticated the child is really suffering from nephritic colic. Hence it is proper when a child is very restless and its actions denote pain, to examine its napkins for the reddish-brown stain characteristic of lithiasis. If small concretions be found, the author advises exploration of the urethra and bladder of the anæsthetized patient. This same examination should be made in every case of chronic dysuria. In cases where the stream of urine is abruptly checked, in cases of prolapsus ani, priapism, and blood in the urine in children, the presence of calculous disease should be suspected. The treatment of lithæmia in children is considered as dietetic, medicinal, and surgical. The ingestion of large quantities of fluids, the restriction in nitrogenous foods, is as usual required. Warm baths are strongly recommended. The solvent treatment by administration of alkalies or acids is applicable in cases of simple gravel, and in the early period of the formation of concretions, but it ceases to be so when the urine becomes ammoniacal, and secondary deposits accumulate on the surface of the stone. When the stone, and the uric-acid variety in particular, is of considerable size, the solvent treatment by medicine will be useless, and recourse must then be had to surgery. The age and sex of the child and the size of the calculus will then determine the choice in the various operations for crushing or cutting for stone.—ELIZABETH STOW BROWN, M.D.

ON STROPHANTHUS.

In THE MEDICAL ANALECTIC for March 22, 1888, the botanical, physiological, and therapeutical characteristics of strophanthus were set forth by Dr. E. T. Doubleday in a leader which contained about all the knowledge concerning the drug then at our command.[1] The advances in our knowledge since then have chiefly been in the direction of ascertaining the exact pathological condition in which the drug is indicated. Very few additions to our knowledge of its physiological effects have been made, they having been early and pretty accurately determined.

Lemoine[2], of Lille, in experiments upon animals, has found that prolonged administration of the drug causes active irritation of the kidney amounting, in some cases, to an active hyperæmia and small hemorrhages in the cortex, the animals having polyuria and albuminuria invariably. Occasionally tetaniform manifestations, like those produced by strychnine, were noticed.

Among the untoward results, vertigo, headache, mental depression and hallucinations have been noticed by Thallon[3] and others.

Dr. Horace Y. Evans,[4] of Philadelphia, Pa., has seen alarming symptoms in a girl of five, who had thirty minutes previously been given by mistake of the mother *twenty drops* of the tincture of strophanthus.

The face was flushed, lips scarlet, eyes brilliant, elevated temperature, skin dry, tongue normal; pupils quivering, dilating and contracting alternately every few seconds; pulse 140, arteries distended, left ventricle contracting with unusual vigor, aortic valves closing with a loud and distinct "tup," a slight mitral regurgitant murmur; intellect clear. The child was precociously loquacious during the five hours in which the toxic symptoms were apparent.

The treatment was half-drachm doses of fluid extract of ipecac with copious drinks of warm water, repeated every ten minutes until the child had vomited five times, then followed with a half drop of tincture of aconite and one drop of the ipecac every half hour until the skin moistened and the pulse became normal. No urine was passed for ten hours after taking the drug.

Considerable discussion has lately taken place in Paris concerning the comparative value of strophanthus and its alkaloid.

Sée thinks the alkaloid alone should be used and asserts that the crude drug is di-

[1] See also MEDICAL ANALECTIC, 1888, pp. 254, 384.
[2] *L'Union Méd.*, Oct. 25, 1888.
[3] *Brooklyn Med. Jour.*, May, 1888.
[4] *Med. News*, June 16, 1888.

uretic simply because it contains some renal poison. Others, like Bucquoy, think the crude drug more useful than strophanthus, which, they think, does not represent the entire active ingredient of the drug.

Dujardin-Beaumetz asserts[1] that oleander has the same physiological effect as strophanthus, and that their active principles are similar.

The same author,[2] disagreeing with most authorities, thinks the drug useful in dropsy of renal origin. He says its only drawback is the diarrhœa produced by its prolonged use. He thinks it incapable of producing a nephritis. He discontinues it if it has no effect in 24–48 hours.

The antipyretic action of the drug continues to attract attention, Rovighi,[3] of Boulogne, finding it a constant result of its administration in febrile conditions. His observations, however, were confined to tubercular and typhoid conditions confirmatory results have been published by Poulet.[4]

Dr. G. R. Butler,[5] of Brooklyn, tried the drug on fourteen phthisical patients, finding that it slowed the pulse and relieved the dyspnœa and muscular weakness.

A case of chronic pneumonia, with an intercurrent attack of bronchitis, exhibited very plainly the effect of strophanthus on the pulse.

Functional irregularity of the heart, occurring in three cases, was very successfully controlled by strophanthus.

Two elderly patients, in whom the process of compensative hypertrophy was at a standstill, with degenerative changes presumably occurring, were noticeably relieved by this drug.

In a case of chronic cardiac and renal disease, acute suppression of urine having supervened, it strengthened and regulated the pulse, but had no effect in promoting diuresis, death occurring in forty-eight hours.

The writer thinks, as compared with digitalis, strophanthus is rather a cardiac stimulant than a cardiac tonic, as its effects are more or less evanescent.

In his experience it has been effective in about two thirds of the cases in which it has been administered, and is more particularly adapted to pulmonary disease attended with cardiac weakness, to functional cardiac affections, and to degenerative conditions of the cardiac muscle.

Bucquoy[6] is very enthusiastic over the drug. He considers it beneficial in almost all cardiac diseases, admitting, however, that, in angina pectoris and exophthalmic goitre, it is of limited utility. He finds it almost impossible to formulate the contra-indications of the drug, saying, however, that, in advanced heart disease complicated by arterio-sclerosis and renal disease, it, like digitalis, is useless.

Dr. J. G. Dale,[7] of Lemont, Pa., has used the drug with benefit, but claims no cure, in a case of exophthalmic goitre. He considers its effect in typhoid fever most happy, as in his hands it relieved the cardiac weakness, breathlessness, feeble heart-sounds, slow pulse, and cold extremities existing in several cases during the apyretic period preceding the stage of convalescence.

In those cases where dyspnœa appears to depend upon coronary disease, Sée finds[8] that a combination of an iodide and strophanthus gives speedier relief than either one alone.

[1] *Le Praticien*, Jan. 21, 1889.
[2] *L'Union Médicale*, Jan. 17, 1889.
[3] *Ann. et Bull. de la Soc. de Méd. d'Anvers*, July and Aug., 1888.
[4] *Bull. Gen. de Therap.*, Feb. 27, 1888.
[5] *Brooklyn Med. Jour.*, May, 1888.
[6] *L'Union Méd.*, Jan. 10, 1889.
[7] *Med. News*, Dec. 29, 1888.
[8] *Le Praticien*, Jan. 28, 1889.

OCCASIONAL REPORT ON RECTAL DISEASES.

BY CHARLES B. KELSEY, M.D.

Bryant (Thos.) on the Diagnostic Value of Ballooning of the Intestine in Cases of Stricture of the Bowel.—The rectum in its normal condition is a collapsed tube, and when the finger is introduced into this tube in its healthy state, the walls of the bowel are found in contact, and these must be separated to complete the examination. When a stricture exists high up in the rectum beyond the reach of digital examination, this condition is sometimes absent, and the surgeon will find, after passing his finger through the sphincter, that he has entered a cavity the walls of which are expanded or "ballooned," and will only be felt when searched for. The extent of the ballooning will vary in every case, but when it exists the

surgeon will be justified in more than suspecting a stricture.

The author believes the condition to be due primarily to atrophy of the muscular walls, brought about by the arrest of all peristaltic action from above at the seat of the stricture ; and secondarily, to the distension of the atrophied bowel by retained flatus. The condition is analogous to the patulous anus and want of fæcal retention seen in cases of stricture lower down in the rectum.—*Lancet*, Jan. 5, 1889.

Bangs (L. B.) on Spasmodic Urethral Stricture from Anal Fissure.—The author reports what seems to be a well-marked case of spasmodic stricture of the deep urethra, cured by the cure of an anal fissure.—*Med. Record*, Jan. 26, 1889.

Allingham (H. W.) on Prolapse of the Gut after Colotomy.—The author has found trouble from the tendency of the colon to prolapse after inguinal colotomy, and he has not found that diminishing the length of the incision overcomes the tendency to protrusion. He attributes the prolapse to undue length of the mesentery and recommends the removal of all the protruding part. He pulls out as much of the gut as possible through the wound and applies sutures. In from twelve to seventy hours afterwards he removes all these bunches of intestine, first applying a spiked clamp about an inch from the wound to prevent the intestine from slipping, and leaving this *in situ* as long as bleeding occurred on relaxation. The operation though severe and dangerous he believes justifiable in all cases of colotomy for non-malignant disease.—*Med. Press*, Jan. 16, 1889.

Cripps (H.) on the Pathology of Hæmorrhoids. — The classification of hæmorrhoids into capillary, arterial, and venous, which is due to Allingham, has not stood the test of observation. Cripps, in his work on the rectum, writes as follows: "The fact of blood escaping in jets has led some high authorities to regard it as arising from small arterial twigs. With due deference to such eminent authorities, I am of the opinion that they are mistaken, and do not believe that the blood ever comes from the arteries, but that the jet is due to its being forced as a regurgitant stream through a minute orifice in a vein by the powerful pressure of the abdominal muscles."

He now reiterates this opinion, holding that the fact that the blood so escapes only when the abdominal muscles act and the veins are subject to pressure, shows that its source must be venous. If it were arterial, the effect of straining and pressure would be to diminish rather than promote the spurting. Apart from this evidence, he has more than once detected the actual opening in the vein from which the stream escaped. In one case, that of a woman reduced almost to death's door by hæmorrhage, recurring for many months when at stool, he observed on the summit of one of the piles a little adherent clot of blood. On removing this it was found to be blocking up a minute circular opening in the wall of a dilated vein, into the interior of which a fine probe could be easily passed.

In another case in which the jetting was a prominent symptom, he discovered an exactly similar opening after wiping away a projecting clot. On telling the patient to strain down, a minute jet was immediately expelled a distance of several inches.

He believes there is no evidence, either from life or post-mortem examination to show that a pile ever consists of varicose arteries.—*Brit. Med. Jour.*, Dec. 15, 1888.

Penrose (C. B.) on a Case of Intestinal Obstruction from Cancer in the Descending Colon with Colotomy and Subsequent Closure of the Artificial Anus.—The patient, a woman aged fifty-two, had had no movement of the bowels for twenty-eight days before the operation. Before this, a movable mass had been discovered in the left inguinal region and diagnosticated to be cancer of the descending colon. Laparotomy with median incision was first performed, and a loop of gut incised to permit the escape of flatus and fluid fæces. This opening was then closed with a continuous silk suture. In the attempt to bring the constricted part out of the abdominal incision, the gut was torn completely across at the seat of disease. As the growth involved the whole lumen of the bowel, and completely closed both ends, there was no escape of fæces.

The stricture, with about ten inches of contiguous thickened intestine and a triangular piece of mesentery, was excised. The upper end of the gut was turned over the parietes, and a large quantity of flatus and a bucketful of green fluid fæces allowed to escape.

The two ends of the gut were stitched together for one half their circumference

with a continuous silk suture, penetrating all the coats of the bowel. The ends were then stitched to the lower end of the abdominal incision by a similar suture. Convalescence was uninterrupted.

About four months later, Dupuytren's enterotome was applied to the spur. It came away at the end of seven days, and the bowels were moved by the natural anus; and after this the bowels continued to move daily, partly by the natural and partly by the artificial anus. One month later the enterotome was again applied and the spur divided to the extent of an inch and a half. This also came away in seven days, and the bowels were moved for two weeks chiefly by the natural anus.

Two months later the edges of the artificial anus were freshened by removing a circular strip of skin about a third of an inch in width, and a contiguous circular strip of mucous membrane about half an inch wide. An elliptical disk of rubber, one sixteenth of an inch thick, with a long axis of one and a half inches, was covered with four silk ligatures placed symmetrically around its edges, and was introduced into the artificial anus on the plane of the parietal peritoneum—thus forming a floor for the abdominal opening and protecting the intra-abdominal line of incision from fæces and flatus. The four silk sutures were passed through the parietes to hold the disk in place. The freshened edges of the artificial anus were united with silkworm gut. A rectal-tube was used continuously for the first two days. The bowels were moved by enema and salines on the fourth day. The sutures were removed on the tenth day, and the silk sutures holding the rubber disk were cut. The disk was passed by the rectum on the sixteenth day. —*Med. News*, Dec. 15, 1888.

Cousins (J. W.) on Topical Remedies for Disorders of the Rectum and Anus.—In cases in which surgical intervention is for any reason contraindicated, the author gives some valuable hints as to local treatment, and the best way of using it.

In cases of obstinate constipation, with consequent straining and engorgement, he recommends the injection, just before the stool, of a smooth and creamy mixture of lanoline and glycerine, containing a few grains of boracic acid.

In cases of pruritus he advises, when the skin is red and moist, the use, after each evacuation, of well-washed soft soap made into a smooth compound with the alcoholic solution of coal-tar, pinol, or the oil of eucalyptus. After the lavement the parts must be well dried with a soft cloth and dusted with a fine powder composed of carbonate of bismuth, oxide of zinc, and starch. He uses the same in cases where the skin has become hard and thickened—cases often associated with this gouty diathesis, and requiring appropriate constitutional treatment.

In the local treatment of prolapsus and hæmorrhoids, and also in cases of operations about the anus or genitals, he recommends a metal pan with a deep well at the bottom for irrigation. The patient sits on the edge of this well, which is supported on short legs, and the genitals are completely submerged. It can be arranged with inlet and outlet pipes for continuous irrigation. After the bowels have been moved by the emollient injection the parts are well irrigated and replaced and an injection given containing a little oxide or chloride of mercury and a few grains of iodoform.

For bleeding during defecation he employs an ointment of persulphate of iron, or a solution of witch-hazel. For anodyne applications he uses cocaine, or a mixture of cocaine and morphine.

For solid applications he employs what is popularly called the American applicator, and for fluids a small soft-rubber syringe, with hard-rubber nozzle, similar to the insufflator used for dry powders.—*Med. Press*, Dec. 15, 1888.

Kelsey (C. B.) on the Treatment of Fistula.—The author deals more especially with the more complicated forms of this disease; with the methods of avoiding incontinence of fæces in operating upon severe cases; and with the various operations for the cure of incontinence following extensive cutting. He finds it necessary to modify the old rule of laying open all tracks with the knife, often cutting only one or two of the chief ones as a primary operation, and treating the remainder with injections and by cauterization. He seldom divides both sphincter muscles in more than one place as a primary operation.

Incontinence following operations he believes to be due rather to a vicious cicatrization, by which the ends of the muscle are not brought into contact, than to the number or extent of the incisions; and

diagrams are given showing some of the methods of operating for this condition, both with the knife and cautery.—*Med. Record*, Feb. 16, 1889.

THERAPEUTICS.

Runeberg (J. W.) on Mercurial Poisoning from Subcutaneous Injection of Calomel.—Inasmuch as the subcutaneous injections of insoluble mercury salts has of late been much recommended and used, two cases reported by this author are of interest, showing the dangers from this method of treatment, and the length of time that the insoluble salt remains in the place of injection, during which absorption into the general circulation takes place. The first case was that of an anæmic woman, thirty-four years of age, affected with syphilis. The initial lesion was contracted in January. On the 12th of March she received a hypodermatic injection of one and one half grains of calomel, and the same amount on the 20th of March. On the 31st of March a slight stomatitis was present. April 13th the patient again received one and one half grains of calomel hypodermatically. Fourteen days after she was received into the hospital, suffering from marked diarrhœa and weakness. Examination showed an extensive ulcerative stomatitis, *fetor ex oris*, the stools very watery and evil-smelling. Urine, sp. grav., 1013; no albumen. Her condition steadily grew worse, diarrhœa continued, the stomatitis increased in extent, slight fever was present, and on May 6th the patient died. Autopsy showed nothing especial, except in the intestines, where the mucous membrane of the large intestines, especially on the tops of the folds, was found to be curved and infiltrated by a diphtheritic membrane, which in spots had been cast off, leaving behind deep ulcerations. Incision into the spot where the last injection had been made released about two drachms of a thick, grayish-white fluid resembling pus, the walls of the cavity containing it being discolored and formed of softened muscle-tissue. Examination of the fluid showed the presence of a large amount of mercury. The previous bad condition of the patient no doubt contributed to the fatal result, but the fact that three weeks after injection was made mercury was found at the site of injection, shows the difficulty of controlling or limiting the absorption of the drug when administered in this way. The author quotes a second case of a well-nourished man, thirty years of age, and affected with syphilis, who received two hypodermatic injections of calomel, a week intervening between the two injections. On the second day after the second injection, profuse salivation and well-marked stomatitis were present, with diarrhœa, vomiting, and anuria. The patient died six days after the last injection, and autopsy showed deep diptheritic infiltration of the large intestine, giving rise to perforation at the sigmoid flexure, with peritonitis following; also acute parenchymatous nephritis and ulcerative stomatitis. A number of other cases are quoted, some of them doubtful, illustrating the same point. All the cases except the second one given above occurred in anæmic patients, or in those weakened by disease, and the author considers that here, the subcutaneous injection of insoluble mercury salts is contra-indicated. He is inclined to attribute the rapid acute course which the second case ran to the possible direct injection of the medicament into a vein.—*Deutsche med. Wochenschrift.*, Jan. 3, 1889. WALTER VOUGHT, M.D.

Abortive Treatment of Gonorrhœa after Cocaine Anæsthesia.—A member of the Society of Medicine and Pharmacy of Isère treats gonorrhœa in the following way: He first washes out the urethra with a large amount of aseptic water, and then fills it with a ten-per-cent. cocaine solution. After leaving this injection in for about five minutes it is allowed to escape, and what remains is washed out with more sterilized water.

The urethra now being anæsthetized, an aqueous solution of silver nitrate, of the strength of 1 to 25, is injected into the urethra as far as any inflammation is supposed to exist. In the writer's experience this application neither produces nor is followed by any pain.

The complete removal of the cocaine solution is necessary, because of the incompatibility between the silver solution and the hydrochlorate.

As the discharge lessens, a sulphate of zinc solution, 1 to 500, is generally indicated.—*Jour. de la Soc. de Méd. et de Phar. de l'Isère*, Dec., 1888.

Turney (J. P.) on Quinine as a Surgical Dressing.—During the year of

1881 I was called to attend a patient who had been thrown from his horse into a bunch of brush, and his head and face cut and bleeding profusely. I stopped and washed the wounds, but there was a persistent oozing of blood. I gave the cuts and scratches a good heavy coating of quinine, strapped the larger wounds, and went on my way. Some days later I met the man, and, to my surprise, found the wounds all healed and scarcely a scar to be seen.

During and in fact since 1881, I have used dry quinine only, as a dressing, and have yet to see erysipelas develop in a wound where it was used.

On the 7th day of August, 1885, a team ran away, throwing a woman, 65 years of age, from the hack. One of the wheels passed over her face and head in an oblique direction from the mesian line of the forehead, just below the hair, down to the malar process, laying the zygomatic arch bare, and terminating at the angle of the lower jaw. The flap thus torn loose was covered with dirt and sand. The wound was well washed, and I covered the entire surface with dry quinine, approximated the edges and stitched them together, after which I covered the outer surface with quinine, and applied absorbent cotton held down with strips of isinglass plaster. The old lady was under my observation until the wound healed, and then went to her home some twenty miles distant. I wish to remark here, that there was never, to my knowledge, a single drop of pus formed in the wound, and the entire flap, with the exception of a small portion at the inner canthus of the eye, healed by first intention. I saw the patient about a year afterwards, and the cicatrix was barely perceptible.

A man jumped from a wagon, striking on hard ground, sustaining a compound comminuted fracture of the tibia and fibula, just above the ankle joint. A great portion of the cancellated structure of the tibia was driven down and compressed until it bulged up and stuck out just above the internal malleolus as large as a hickory nut, the upper fragment protruding through his flesh, drawers, pants, and into the ground. I used as a dressing nothing but dry quinine, covered with a layer of absorbent cotton, over which I laid a piece of carbolized gauze, and covered the whole with a piece of oiled silk, held in place by a roller.

The accident occurred on the 15th day of November, and on the 3d day of December the patient sat up in his room, and has improved steadily since. I used a splint which gave me free access to the wound.

The following prescription,

℞.—Quiniæ sulph. . . ʒ i.
Adipis . . . . ʒ i.,

I have used as a local application in facial erysipelas, and when the face was so swollen that it seemed ready to burst, have seen the swelling subside in a few hours, as if by magic. Any one who will try quinine as a dressing, will find in it a clean, non-poisonous, and efficient dressing, devoid the disagreeable odor which accompanies iodoform or carbolic acid, and without the danger of bi-chloride of mercury.—*Cincinnati Med. Jour.*, Jan., 1889.

Coe (H. C.) on Paralysis of the Third and Sixth Cranial Nerves Following Moderate Doses of Quinine.—A woman of forty-five entered the Cancer Hospital with extensive scirrhus of the left breast, the axillary and supraclavicular glands being greatly enlarged. He operated October 22d. Owing to a serious error in the preparation of the sponges, the wound suppurated so that he was obliged to open and allow it to heal by granulation. During the first two or three days there was an evening rise of temperature to 102°, but subsequently it did not rise above 100°. The pulse remained at 120 and higher for two weeks and was rather feeble, but under three-minim doses of tincture of strophanthus, four times a day, it was finally reduced. The wound soon granulated and convalescence apparently set in, except that at the end of the third week there was still a daily rise of temperature to 100°. After a review of the case, he had come to the conclusion that this daily febrile movement might be due to malarial toxæmia, of which the patient gave a clear history. Quinine was given in doses of five grains four times a day with a drachm of dilute hydrobromic acid. This treatment was begun November 12th, the strophanthus being discontinued. On November 16th it was noticed that the patient had internal strabismus of the left eye, with slight ptosis. It appeared, on questioning the patient, that ptosis with slight internal strabismus of the left eye had developed on a previous occasion after

the continued administration of fifteen grains of quinine daily. He had at once suspended the drug, one hundred grains having been taken in all. The paralysis became more marked, so that two days later the patient could not see to walk or even to grasp objects. Then the strabismus had improved radidly, the ptosis more slowly, till at the present time there was only a decided droop of the left eyelid and a slight squint. No treatment had been employed.—*N. Y. Med. Jour.*, Feb. 16, 1889.

Geraty (T.) on Poisoning by Citrate of Caffeine.—At 9 A.M. before breakfast, a woman suffering from migraine took a dessertspoonful (equal to 200 grains) of pure citrate of caffeine in mistake for the granular effervescing form of the drug. I saw the patient immediately after the accident; the only complaint she then made was as to the nauseating taste. I encouraged her to eat a little porridge before having an emetic. As soon as the porridge was eaten, faintness and nausea came on; and a quarter of an hour after the reception of the poison there was semi-unconsciousness, grave depression, extreme pallor, all the muscles completely relaxed, and a decided inclination to sleep; pulse slow, soft, and very compressible; respiration slow and sighing. The treatment adopted was an early emetic (one twelfth of a grain of apomorphia), which acted at once and very completely, small quantities of brandy, the recumbent position, and warmth. I may say there was a well-marked rigor about an hour after the caffeine was taken. Consciousness was recovered about an hour and a half after emesis, and the faintness passed gradually away.—*Lancet*, Feb. 2, 1889.

Experimental Iodoform Poisoning.—Dr. A. V. Koriander of St. Petersburg has endeavored to throw some light on the vexed question of the suitability of iodoform for use as an antiseptic by poisoning dogs with it, and examining the morbid appearances *post-mortem*. The iodoform was introduced into the peritoneal cavity in quantities varying from 0.3 to 1.5 gramme per kilog. of the animal's weight. The microscopic sections of the organs were stained by hæmotoxylin and lithion-carmine. Nephritis affecting the renal glomeruli was invariably found, and the liver was infiltrated by minute fat granules. These appearances are considered by the author to be characteristic of iodoform poisoning.—*Lancet*, Jan. 19, 1889.

Hare (H. A.) on the Use of Barium Chloride in Heart Disease.—All observers are in accord in the statement that barium chloride slows the heart very greatly, steadies its rhythm, and at the same time increases the volume of blood thrown out of the ventricle. They have also found that barium increases blood pressure, and Kobert has, by a series of careful experiments, concluded that it brings about this change by an action on the muscular coats of the blood-vessels.

If large doses are used in the lower animals, the heart suffers systolic arrest from over-stimulation, and the strongest irritation of the vagus nerves fails to relax the systolic contraction. Still more interesting is the statement that this failure of the vagi to inhibit the heart is not the result of paralysis of these nerves, but is simply due to the excess of cardiac contractile power. The slowing of the pulse is not due to inhibitory influence, but depends solely upon the stimulation of the heart muscle, although it would seem probable that the vaso-motor stimulation, by increasing the arterial resistance, may be, at least, a factor in the reduction of the pulse-rate. At one time, in the dog after large doses there is a period of increase of pulse-rate which is asserted to be due to stimulation of the accelerator nerves.

The author has employed the remedy clinically in several cases with the following results:

Case 1. A girl of six has had for some months marked dyspnœa at night and some shortness of breath during the day. She has a history of rheumatism of a mild type. Examination shows a loud mitral systolic murmur, which is quite faint over the apex, and increases greatly in volume as the ear follows it to the left axilla, while at the angle of the left scapula the murmur is remarkably loud. There has been no dropsy at any time.

Half a drachm of solution of the strength of 1 part of barium to 100 parts of water were given three times a day. From the first the condition of the child at night was markedly improved, the dyspnœa was much less, and the sleep not so restless. The pulse, which had been at 130 per minute, now remained at 80 when quiet, or 100 after exercise, and the area of the thrill over the apex was much less diffused than

before. One of the chief evidences of improvement was the absence of that peculiar whirring, tumbling sound, so characteristic of such cases, the murmurs becoming well separated from one another, and having a much more definite character.

The continued use of the barium in this case for over two weeks has caused no untoward symptoms, and the child has steadily improved, notwithstanding an attack of mild bronchitis in the meantime.

Case 2. A man of thirty-five, with acute dilatation of the heart, the result of suddenly lifting a very heavy beer-barrel. His pulse was weak and irregular, and he frequently suffered from attacks of pain closely resembling angina pectoris, with marked expression of anguish. The use of barium chloride in the dose of a teaspoonful of a 1 per cent. solution relieved him markedly, increased the volume and force of the pulse wave, and slowed it to as low a rate as 60 or even 58 per minute.

Case 3 was a man of about fifty, with a double aortic regurgitant murmur, complicated by Bright's disease of a benign type, in so far as the renal signs were concerned. There was some pain over the region of the heart. Under the influence of the barium, in drachm dose of the standard solution, the pulse became much slower and far more forcible.

Case 4. A colored man of fifty, suffering from aortic regurgitation, producing a very loud murmur, was placed upon the dose always employed in these studies. The pulse rapidly became more full and strong, and the comfort of the man was considerably increased.

Case 5. Adult, male, with a well-marked mitral regurgitant murmur. The pulse rapidly became slower and the beat more rhythmical under barium chloride. Before the drug was used the morning pulse-rate ranged from 108 to 92, while after the first dose the pulse went down to 72, and remained between this point and 60 until he was discharged from the house.

Cases 6 and 7 consist of two men who suffered from marked weakening and diminution of the pulse wave, and of irregular and excitable heart respectively. In other words, no lesion could be discovered save that of functional disorder. In both men barium chloride brought about a very rapid improvement in the cardiac state.—*Med. News*, Feb. 16, 1889.

MEDICINE AND PATHOLOGY.

A Case of Raynaud's Disease Associated with Neuritis.—In the *British Medical Journal* of Dec. 8, 1888, Dr. J. O. Affleck records two cases of Raynaud's disease, one of which deserves especial mention. The phenomena were confined to the feet, and differed only from the type of disease, as described by Raynaud, in the extent of the gangrene which followed. The whole of the anterior part of the left foot became gangrenous. The tips of the four smaller toes only were involved on the right foot. On the former a Syme's amputation was performed, resulting ultimately in a good stump. The plantar nerve of the amputated foot showed marked neuritis, parenchymatous in character, apparently (judging from the cut given in the journal). The blood-vessels leading to the part were healthy.

This adds another to the several cases of symmetrical gangrene already reported in which neuritis was found. The author raises, but does not venture to answer the question, as to whether the neuritis was primary or secondary. It is of interest to recall the fact that in the cases of symmetrical gangrene with peripheral neuritis recorded by Pitres and Vaillard (Schmidt's *Jahrbücher*, 1885, Bd. 206, p. 25), they regarded the neuritis as primary, basing their opinion on the absence of neuritis in a case of senile gangrene from arterial disease.

R. Van Santvoord.

Kiernan (J. G.) on Mental Symptoms after Surgical Proceedings.—Under the title "delirium traumaticum nervosum" the older surgeons described a number of mental symptoms which made their appearance after surgical operations. These symptoms usually consisted of great motor agitation, visual and auditory hallucinations, excessive loquacity, and exceptionally the delirium was of a stuporous type, and still more rarely, the symptoms were of a very violent type. The patient generally made a rapid and full recovery. Exceptionally death resulted from the delirium, and still more exceptionally the patient remained permanently insane.

Scheede reported many cases due, he claimed, to iodoform; others were charged to carbolic acid, and still others to mercury bichloride. There was no great improba-

bility in this etiology, for the mental phenomena were such as these agents do produce. Cases occurred, however, where the influence of antiseptics could be excluded. Then the symptoms were charged to blood poisoning, but in the majority of instances there was no evidence of this. This complication has been observed in 80 cases after various surgical procedures, according to a not very thorough research I have made of the literature. Thirty cases occurred after cataract operations. Thirty resulted after gynæcological procedures. The remainder resulted from plastic operations, amputations, dental procedures, etc. In 15 cases there was larvated epilepsy precedent to the operation. In 10 hysteria major was present. In 15 cases a neurotic element existed. In 25 cases the patients had arrived at periods of involution when instability of the nervous system usually results. In 6 cases the influence of blood poisoning was demonstrated.

The prognosis in the larvated epileptic cases was good so far as the mental phenomena was concerned. The same is true of the neurotic and hysterical cases. In some of the cases occurring at the period of involution senile degenerations were precipitated. The majority of the blood-poisoning cases died. As a rule the type presented was that of acute confusional insanity. Ordinary epileptic and hysterical insanity resulted in cases of larvated epilepsy, and hysterical insanity in hysterics. Typhomania at times occurred.

According to certain estimates, about two per cent. of the gynæcological procedures and the same per cent. of cataract operations are followed by psychical symptoms. The etiology is clear in most cases. The antecedent conditions of the patient as to age and constitution act as a predisposing cause. The mental agitation precedent to the operation is a direct exciting cause.

The moral treatment of the patient antecedent to operation, supplemented by proper medicinal treatment, is the best prophylaxis. Sedatives and other measures tending to calm agitation are necessary. In most of these cases conium is indicated. Opium, and not chloral hydrate or the bromides, will, as a rule, be found of most value in a majority of cases. In hysterical and epileptic cases these latter remedies are indicated. In many of the hysterical cases salix nigra and monobromate of camphor give good results.—*Chicago Med. Jour. and Examiner*, January, 1889.

Daland on Caries of the Atlas and Axis.—This example of caries occurred in a man, æt. 70. About a year ago, while lifting a heavy weight, he felt something give way in the neck, and the head fell backward, then forward. Soon he complained of pain and stiffness in the neck, and repeated crops of herpes zoster showed themselves. He became unable to rotate the head, only a slight power of nodding remained, and complete paralysis of the arms and legs appeared, but with no loss of power over the bladder. The paralysis afterward cleared up when a retro-pharyngeal abscess was lanced. The reporter attributed the trouble to a rupture of one of the ligaments, and a subsequent extension of the inflammation to the bone. He referred to the frequent connection of herpes zoster with organic disease, and thought the paralysis due to pressure, as it had been completely relieved by opening the retro-pharyngeal abscess.—*University Med. Mag.*, Jan., 1889.

Dalziel on Carcinoma Affecting the Os Calcis.—No clinical history could be procured. Presumably the tumor was a secondary one. The skin of the heel had remained entire, though much distended by the neoplasm, which was about the size of an orange, and had by its pressure eroded the os calcis, so that only a shell next its articular surfaces remained. The tumor was a very old one, and had been formerly labelled sarcoma, but under the microscope the sections showed it to be a typical and very beautiful specimen of carcinoma of the scirrhous variety, dense bands of fibrous tissue forming the alveoli, in which were the collections of epithelial cells.—*Glasgow Med. Jour.*, Jan., 1889.

Ord on Death from the Presence of a Caseous Gland in the Trachea.—A healthy-loooking boy, aged five years, was admitted at 7 A.M. on Nov. 29, 1888, into St. Thomas' Hospital, suffering from great dyspnœa, lividity, and cough of four days' duration. According to the parents, he had coughed up a thick piece of phlegm the preceding night. Rhonchi were heard over both lungs. An emetic was given, and at 10 A.M. the child seemed fairly well. He continued well until December 9th, when he was discharged. During his stay

in the hospital his temperature rose, once to 104° and at other times to 102°, for no apparent reason. On December 18th he was readmitted to the hospital, suffering from still greater dyspnœa, especially well marked on expiration. Rhonchi were heard over both lungs, and the child was in very great distress. Stimulants and expectorants were administered, but he died at 2 A.M. on the 19th. At the post-mortem examination held the next day, both lungs were collapsed, and there was a little inflammation of the bronchi. But in the trachea, just above its bifurcation, protruding through an opening in the right side, was a caseating gland which had ulcerated through its walls and almost completely blocked it. It was attached by firm adhesions to the margin of the opening in the trachea, much more of the gland being in than out of the tube. A few more caseating glands were found round the trachea and bronchi, but none elsewhere. This is a very rare condition, inasmuch as the gland which caused the fatal result was found lying loose in the trachea, having been "shelled out" from the suppurating cavity. Two similar cases are recorded. It is more common to find caseating abscess cavities communicating with the large air-tubes.—*Lancet*, Jan. 5, 1889.

Johnson (Geo.) on the Clinical History of Intermittent and Latent Albuminuria.—The following are the main points which in this and in previous publications on the same subject the author has endeavored to establish :

1. The presence of albumen in the urine, though small in amount and occasionally intermittent, is always pathological.

2. The practice of testing the urine in all cases of ailments, even the most trivial — the importance of which I have for many years past insisted upon,—has led to the detection of albuminuria in many youths and adolescents who are especially liable to be exposed to the commonest of its exciting causes, namely, cold and wet and over-fatigue, and who have not lived long enough for the ultimate evil results of a neglected albuminuria to have become developed.

3. The albuminuria, whether intermittent or persistent, of persons apparently in good health has no such special features as to require it to be designated by such misleading terms as "physiological," "functional," "cyclical," and "the albuminuria of adolescence." The last term is especially inappropriate, since the condition is of common occurrence in both sexes and at all periods of life, from childhood to extreme old age.

4. In almost every instance these cases of albuminuria may, by a careful inquiry, by traced back to some recognized exciting cause.

5. Nearly all cases of acute nephritis pass through the stage of intermittent albuminuria in their progress towards convalescence, and, on the other hand, the majority of cases of intermittent albuminuria may be traced back to a more or less remote attack of acute nephritis.

6. While, on the other hand, intermittent albuminuria — even though it may have existed for years — may be looked upon as a curable condition, if only its exciting causes can be ascertained, avoided, and counteracted by suitable dietetic, medicinal, and hygienic means ; on the other hand, the neglect of such means may convert an intermittent into a persistent albuminuria ; and a persistent albuminuria, although for many years it may be unattended by symptoms of disordered health, ultimately results in a fatal degeneration of the kidneys.

7. Since it is notorious that albumen, even to a very large amount, may exist in the urine of persons who are apparently in perfect health, it is obvious that the urine of every patient, no matter how apparently trivial his ailment, and the urine of every applicant for life assurance, no matter how robust his appearance, should be tested for albumen.

8. For many years past, the fact that albumen may be abundantly present at one period of the twenty-four hours and entirely absent at another has been publicly demonstrated, and ought to be generally known. It is, therefore, necessary to test the urine, not only after rest in bed and before breakfast, but also after food and exercise.

With regard to the question of albuminuria in life assurance, no prudent medical officer would advise that a proposed assurer with a trace of albumen in the urine should be accepted at the ordinary rate of premium. Such a condition, even in a careful and prudent man, must involve some extra risk, and no office can insure care and prudence.—*Br. Med. Jour.*, Feb. 2, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRUGICAL PRACTICE

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MEDICINE AND PATHOLOGY.

Letulle (M.) on Mercurial Tremor.—The patient, a man of thirty-nine, was, at his work, exposed to emanations from the acid nitrate of mercury. For eleven years he suffered in no way except his teeth became black and fragile. At this time he served three years in the army and then resumed his trade. Ten years later he was seized with his first attack of mercurial tremor. A course of sulphur baths and iodide of potassium relieved but did not cure him. The tremors were worse in the morning, almost imperceptible about 4 to 5 P.M., and again very marked in the evening.

Suddenly one day the tremors became so violent that the man was thrown down by them and so violently convulsed that he could not walk, and in this condition he was brought to the hospital.

When perfectly at rest on the bed the movements were slight, but they were very much intensified by any voluntary effort. The motions were extensive, rapid, arhythmic, not like those of any disease, though choreiform, and were perhaps more marked upon the left side. There was an anæsthetic area on the back of the right forearm and hand, and the man said that since the first attack of tremor his vision had been impaired. There was some narrowing of the left visual field without any notable color-blindness.

These peculiar symptoms led the author to denominate the ailment *mercurial hysteria.*

The author accidentally discovered that constricting the limb would check the tremor, and he finally permanently stopped it by the application of an elastic ligature and the passage of a magnet up and down the limb.

He therefore concluded that mercury in a case like this produced no serious structural lesion in the brain or cord, but appeared to exalt in a singular way the activity of the nervous centres and profoundly disturb the harmony which governs their functional synergy.—*La France Méd.* Nov. 8 and 10, 1888.

Desnos on Rapid Muscular Atrophy during Pregnancy.—The woman, pregnant for the third time, was seized with uncontrollable vomiting. Wasting and weakness attacked the extremities, the lower being almost powerless. The condition was so alarming that premature expulsion of the fœtus was thought necessary and was brought about with no untoward results. Improvement set in at once, sufficient food being taken. The strength returned, but the atrophy remained stationary, getting no worse. Treatment by electricity and hydrotherapy produced immediate improvement, and a perfect cure was expected.

The author thought a general neuritis or myelitis was the cause of the symptoms.—*Le Courrier Méd.*, Dec. 1, 1888.

. The Treatment of Tabes and Other Diseases of the Nervous System by Suspension.—Charcot, acting on suggestions made by Dr. Motchoukowsky, of Odessa, has been treating his cases of locomotor ataxia by suspension and the application of a plaster jacket. It is

claimed that all the symptoms of that disease are relieved by this procedure, viz., the inco-ordination, vesical troubles, fulgurating pains, anæsthesia of the soles, and even the impotence.—*La France, Méd.* Jan. 29, 1889.

[This is all too good to be true, and further experiment will undoubtedly prove the fallacy of these hasty deductions.—ED.]

Debove on the Permanent Slow Pulse and Uræmia.—Referring to those cases of permanent slow pulse (28 to 30 per minute), in which Charcot has said a medullary lesion must exist, the author has, in just such a case, examined the medulla and found no lesion. He recently had under his care a man of eighty, who had been seized, during a course of dyspnœic attacks, with syncope and epileptiform attacks. His pulse was 32. His heart and lungs seemed normal. He was passing about 600 cc. of urine a day, which contained from 7 to 8 grammes of urea and no albumen. Milk diet caused a diuresis and an increase of urea up to 20.5 grammes a day, and the dyspnœa disappeared, the slowing of the pulse continuing unchanged. Gingeot has seen the pulse rise from 32 to 40 on the accession of an acute bronchitis in a similar case, while the axillary temperature was 102°.—*Le Praticien*, Dec. 10, 1888.

Trumbull on a Case of Acute Ulcerative Endocarditis, Limited to the Tricuspid Valve, with Autopsy.—The patient was a man who had been in capital health until about three weeks before he came under Dr. Trumbull's observation. His illness began with chills, fever, headache, inability to continue work, great weakness, loss of appetite, and slight diarrhœa. The temperature was irregular and intermittent; intelligence clear; respiration rapid, varying between 54 and 62 per minute; pulse varied between 120 and 132 per minute; urine albuminous, but contained no casts or blood; there were repeated and irregular severe rigors during the further progress of the case, and frequent attacks of cyanosis and dyspnœa; and the physical signs of pulmonary infarctions developed. There was no enlargement of the heart dulness; and valvular, the sounds were normal, with the exception of an altered systolic at the base, over the left of the sternum, spoken of as a "probable murmur" at the pulmonary valve. Distressing cough without expectoration developed; feet and lower limbs became œdematous; purpuric spots, pin-head in size, irregularly scattered over both upper and lower extremities appeared; on the dorsum of each foot, a large patch of hemorrhagic extravasation. Body of a distinct icteric hue. The patient died about the eighteenth day of his illness. Post-mortem examination showed in the lungs embolic abscesses, and here and there hemorrhagic infarctions.

No enlargement of the heart. Left ventricular wall normal in thickness, cavity filled with soft, easily detached clots. Aortic and mitral valves intact and endocardium nowhere lacking in lustre. Right ventricle full likewise of post- and ante-mortem clots, a portion of which was with difficulty detached from the cordæ tendinæ. Opening the right auricle freely so as to look down on the tricuspid, two crumbly masses of vegetation, like two small flaps of warty growth on the labia minora were seen, three-quarters of an inch long, one-half inch high, and flattened from side to side, looking upward toward the auricle, separating somewhat toward the remaining valve, which appeared wanting, while along the edge of its attachment to the heart-wall roughened spots with points of purulent matter were visible. The cordæ tendinæ were whole, and as seen from beneath the valves were intact. The vegetations grew from the auricular surface of the valves close to the edges, only two being implicated as stated, the third only having points of ulceration where closure made pressure against the verrucous growths.

Spleen large, pulpy, and very friable, weighed one and a half pounds, without any infarctions or infective emboli. Liver enormously increased, weighing seven pounds, solid, firm, and of a grayish-yellow tinge—no abscesses. Kidneys slightly enlarged, capsules non-adherent. Removal disclosed pin-head yellow spots, small abscesses dotting the cortical substance. A wedge-shaped hemorrhagic infarction, size of a nutmeg, found in the right kidney.

In this case the etiology is obscure. We had no antecedent rheumatism, recent or remote, no valvular disease; no trauma as a source of possible infection. The position of the growth on the auricular surface of the tricuspid valves would imply that entrance must have been effected through the venous system. Careful in-

quiry failed to elicit any existence of wound; but having lately read of pyæmia as occasionally resulting from a urethritis, its existence was investigated, to see if even malignant ulcerative endocarditis might be attributed to infection along a mucous tract irritated by the gonococcus; but it was not present.

The case, therefore, one is compelled to admit as a case of *primary* ulcerative endocarditis, solely implicating the tricuspid valves.—*Medical Record*, Jan. 26, 1889.

W. V.

Physiological Heart-Murmurs in Healthy Individuals.—At a recent meeting of the Boston Society for Medical Improvement the occurrence of cardiac murmurs in presumably healthy individuals was under discussion. Two papers were read, by Drs. Morton Prince and J. H. McCollom. Dr. Prince's observations were founded on eighty-six consecutive subjects, applicants for positions in the Boston Fire Department. After eliminating nine cases in which there were co-existing signs indicative of, or suggestive of, organic heart disease, there remained seventy-seven presumably healthy individuals. Of these seventy-seven, a systolic murmur, with all the characteristics of a mitral regurgitant murmur, could be heard in twenty-six cases.

Dr. McCollom found in two hundred men, who were examined for the Police Department, a mitral regurgitant murmur present in twenty-seven instances. Dr. McCollom believed the difference in the results obtained was due to the fact that Dr. Prince's men were more excitable. He further says: I have never observed this murmur in persons of a phlegmatic temperament, neither have I observed it in persons inclined to obesity. Tobacco has some influence in the causation. If the theory of the sphincter-like action of the heart is tenable, then certainly the relaxing effect of nicotine would play a very important rôle. In two instances men have fainted when undergoing examination, and in each instance the murmur was heard before the attack of syncope. The murmurs have generally been soft and blowing, and in nearly all the cases the men have been addicted to the use of tobacco. I consider, however, that the so-called tobacco heart presents an entirely different train of symptoms.

In Dr. McCollom's cases the murmur disappeared in every case, either after the subsidence of mental excitement or after the stoppage of tobacco. After tabulating the co-existing phenomena, it was found that, while no relation seemed to exist between the pulse-rate and the existence of the murmur, it was found that, of forty-two cases in which the strength of the heart's action was recorded, it was above the normal in strength in twenty-nine, natural in thirteen, as follows:

29	Souffle in 19.	
	None in 10.	
13	Souffle in 1.	
	None in 12.	

Again, taking the converse of this, of these twenty cases with mitral systolic murmurs, the heart's action was recorded as above the normal in nineteen, and as natural in only one. The increased strength of the heart's action was also shown by the frequent presence of arterial murmurs.

To explain these murmurs, the mechanism of the mitral valve was discussed, and it was shown how the mitral opening was much larger in diastole than in systole, and that, to close this opening, two actions were necessary: 1st, the sphincter action of the muscular fibres surrounding the opening; and 2d, the approximation of the valve-segments. It was generally recognized that, if any thing weakened the power of the sphincter, regurgitation took place, owing to the valves being too small to fill the opening.

Dr. Prince then maintained the converse of this, as an explanation of the murmurs described in the paper, namely, *given a normal, healthy sphincter, but with excessive pumping action on the part of the heart under strong nervous excitement, and a temporary leakage might occur from the blood being forced through the sphincter in spite of the action of the latter.*—*Boston Med. and Surg. Jour.*, Jan. 31, 1889. W. V.

Boyd (M. A.) on the Disappearance of Cardiac Murmurs.—The author gives three instances of cases under his own observation—one the murmur of mitral regurgitation, with consecutive changes in the left ventricle and auricle, which existed for two years and ultimately disappeared, as did the hypertrophy associated with it; and two others of aortic regurgitation existing for a considerable period, which also finally got quite well. All the murmurs he has met with as thus disappearing were

cases of regurgitation of either the mitral or the aortic orifice. A well established constrictive murmur, in his opinion, never gets well; it might disappear or cease to be heard owing to failure or weakness of the cardiac wall, or excessive dilatation of either these or the aorta; but the symptoms associated with it remain, and *post-mortem* evidence shows no cure. The author believes that plastic material deposited on or in a valve might ultimately get absorbed when it only interfered with their adaptation; but, when deposited around the margin of an orifice, it must ultimately, by its contraction, cause obstruction. Such absorption, he considers, is more likely to take place when the subjects were young.—*Br. Med. Jour.*, Feb. 9, 1889.

Woolridge (L. C.) on Auto-Infection in Cardiac Disease.—Some time ago the author found that lymph and chyle, when injected into the blood, produced poisonous symptoms to which he proposed to apply the term "fibrinogen intoxication." The injection was followed by intravascular clotting, a great tendency to hemorrhages, occasionally marked fever, and a remarkable delay in the clotting of the blood when withdrawn from the body. In order to produce the above-mentioned effects, a certain quantity of the fluid (lymph or fibrinogen solution) must reach the blood in a given time. A small quantity rapidly injected caused instant death, but the same quantity diluted and injected during three or four minutes produced no effect whatever. This seemed to afford an explanation of the fact that normally the flow of the lymph from the thoracic duct produces no poisonous effect. In cardiac disease or disturbance of the circulation through the lungs, the circulation of the blood in the neighborhood of the thoracic duct is materially slowed. This slowing of the circulation would act in the same way as a more rapid injection of lymph. The author believes that the dropsy, which is so common a symptom of cardiac disease, is not due, as is commonly said, to the mechanical disturbance of the circulation; he maintains that the fact that even very slight fibrinogen intoxication produces a pronounced tendency to dropsy renders it extremely probable that the dropsy and other symptoms of cardiac disease depend on "fibrinogen intoxication."—*Br. Med. Jour.*, Feb. 9, 1889.

Ashton (J. H.) on a Case of Rupture of the Heart.—The general health of the patient, a woman of seventy-three, was very good. Three years ago she had an attack of syncope, which lasted one hour and was attended by partial unconsciousness; since then she has been well, with the exception of experiencing shortness of breath when she has had to go upstairs. She had recently an attack of jaundice, which quickly passed away, and since then she has complained of cold feet. She has never suffered from pain in the side, or sickness. On the morning of her death she was about her usual duties, when she suddenly fell down, and died almost immediately.

I found the body well nourished. On opening the thorax, the pericardium was distended by fluid and clotted blood; on removing this, a rupture, three-quarters of an inch long, could be seen on the anterior surface of the left ventricle; this extended through its walls into the cavity, and from it blood could be made to flow by pressure, the cavity of the ventricle being full. The right ventricle was empty, and the tricuspid orifice slightly dilated; the valves were healthy. The mitral valves were somewhat thickened. The heart was not enlarged; the muscular substance was mottled in color, softened, and very easily lacerated; the fibres, examined under the microscope, had undergone fatty degeneration. A large gall-stone almost entirely filled the gall-bladder, and a small hard tumor was found at the lower border of the omentum adherent to the peritoneum and intestines.

It is interesting to note that the large gall-stone gave rise to but trifling, if any, symptoms. The place of rupture was observed to be where the evidences of degeneration were most marked, and, as in the majority of recorded cases, took place in the left ventricle and on its anterior surface; the direction of the rent was in the course of the fibres, and about one third of the distance from the apex to the base.—*Lancet*, Jan. 12, 1889.

On the Frequency of Albuminuria in Healthy People.—A committee of the Connecticut State Medical Society, consisting of Drs. George R. Shepherd, James Olmstead, and F. E. Beckwith, have made a report on the above subject, of which the following are the conclusions:

1st. Albuminuria is much less frequent in the United States than in England.

Stewart giving thirty-one per cent. as the general average of his examinations, while ours, conducted on a much larger scale, will not reach two per cent.

2d. The brain workers rather than the muscular workers show the largest percentage of albuminuria.

3d. That the urine of perfectly healthy people rarely shows albuminuria after food, while that of those who suffer from dyspepsia and oxaluria is very liable to do so.

4th. Privation, scanty food and clothing, with unsanitary surroundings, increase the liability to albuminuria.

5th. Cold bathing does increase the liability to albuminuria, though more notably so in people of dyspeptic tendency.

6th. Severe exercise increases the liability to albuminuria, in a very moderate degree.

7th. In very many instances, albuminuria is not associated with disease of the kidneys.

8th. In the matter of life insurance, albumen in the urine should be looked upon as a symptom only, and the cause ascertained. The acceptance or rejection of a risk should depend upon the gravity of the cause.

9th. When heat and nitric acid detect albumen, the history of the case, aided by the microscope, will in the great majority of instances indicate its source, thus proving physiological albuminuria to be of very rare occurrence.

Squire (J. E.) on the Prevention of Phthisis.—According to the author two changes which must form the basis of any successful attempts to diminish the prevalence of phthisis are (1) a provision of a sufficiency of fresh air in and around dwellings and work places; and (2) an endeavor to improve the resisting power of the individual by physical training during the period of growth and development, and by exercise and recreation alternating with the work of maturer age. As the effects of phthisis are handed down by hereditary transmission from parent to child, any causes which tend to increase tubercular disease among the adult members of a population must be regarded as tending to produce a progressive deterioration of race. It is, therefore, in the interest of the community that no time be lost in commencing a systematic attack upon the preventable causes of phthisis.—*Br. Med. Jour.*, Jan. 26, 1889.

Cockey (C. H.) on Preservation of Urinary Casts.—The urine may be preserved in bottles, and used when desired, or moist mounts may be made, finished in the usual manner and preserved in the cabinet.

There are two formulæ used, one with glycerine and one with acetate of potassium. One formula is: Take of salicylic acid 2 parts, borax 1 part.

Add sufficient glycerine to dissolve.

Add three (3) parts water for coarse organisms, five (5) parts water for fine.

It is needless to say that all water used for microscopic purposes should be *distilled* water.

For the second formula, take of a saturated solution of acetate of potassium, one part, water sixteen (16) parts; mix and add salicylic acid to saturation.—*Maryland Med. Jour.*, Feb. 16, 1889.

Fitz (R. H.) on Hemorrhagic Pancreatitis.—Of the seventeen cases of hemorrhagic pancreatitis studied by the author, fourteen were males and two were females, the sex of one person not being stated. Their ages were as follows:

Years of age.	Number of cases.
From 25–30	1
" 30–35	2
" 35–40	1
" 40–45	4
" 45–50	1
" 50–55	1
" 55–60	2

One was described as a young adult, two as adults, and nothing was stated concerning the age of two.

The patients were usually in good health at the time of the attack, a few of them being conspicuously strong and robust. Nearly one half of them were abundantly or superabundantly provided with fat-tissue.

A small fraction, nearly one sixth, was addicted to the abuse of alcohol. Nearly one half of the cases suffered from previous attacks of indigestion. These attacks were usually characterized by pain which was colicky, gastric, or abdominal, and so severe in one instance as to suggest impending perforation. Vomiting, either watery or bilious, or both, was noted. Nausea, belching, and diarrhœa were recorded. Jaundice occurred in a single instance.

It is obvious from the above statement that the previous digestive disturbances were rather gastric, or gastro-duodenal,

than enteric. The immediate attack began, in the great majority of cases, with abdominal pain, usually without known cause, though rarely some irregularity in diet appears to have been an immediate predecessor. The pain was violent, intense, or severe, either constant or paroxysmal. Its seat was usually in the upper abdomen, and, in one instance, was stated to have followed the course of the pancreas; subsequently, in one fifth of the cases the abdominal pain became general. The initial pain was usually followed by vomiting, more rarely by nausea alone. In one case there was a conspicuous record of no vomiting. The vomiting was constant, repeated, or occasional. It might be copious. It was bilious at times, or black, and contained, in one instance, dark-red clumps the size of peas.

Constipation was a symptom of frequent occurrence, and a diagnosis of intestinal obstruction was made in three instances, in one of which laparotomy was performed. The occurrence of diarrhœa was noted in but one case. Hiccough and albuminuria each were reported in a single case.

Fever was an inconstant symptom. When present it was of early occurrence and might be high on the second day. On the contrary, the temperature might be normal on the first day and subnormal on the following day. Delirium was present in three cases.

A tympanitic swelling of the abdomen was of no infrequent occurrence. It was usually general, or in the upper abdomen, and was generally localized in the lower abdomen. In one case, thought to be of intestinal obstruction, a swollen intestinal convolution was to be felt in the right side.

Symptoms of collapse were almost invariably present, and usually directly preceded death.

This occurred as follows:

On the 2d day in	. . . .	3 cases.
" 3d "	. . . .	5 "
" 4th "	. . . .	3 "
" 5th "	. . . .	2 "
" 6th "	. . . .	1 case.

It took place after a few or several days, each in one case. The diagnosis lay between intestinal obstruction, perforative peritonitis, and an irritant poison. The pancreas was found enlarged, either throughout or at one extremity, usually at the head. The gland was frequently doubled in size, and might seem still larger when abundant fat-tissue was present. The enlargement has been compared to the size of a man's arm. The gland was generally dense, sometimes friable, and has been noticed to be of diminished consistency. The existence of hemorrhage was usually suspected by the appearance of the surface, which is of various shades of red. On section, however, the color may be dark-red, reddish-brown, violet, reddish-black, or even black. The modification in color may be uniformly distributed, or lie in patches, or in specks. The patches correspond with nodules which may project above the surface. These discolored patches may show white specks or streaks, and the red color may lie in the interlobular tissue of the pancreas.

The color of the section may be affected by the presence of associated alterations, one of which is accidental, the other may be incidental. The former is due to an excessive quantity of fat-tissue in the pancreas, sometimes appearing to form nodules as large as hazel-nuts, and to treble the size of the gland. Bands and spots of a translucent yellow are thus produced which are mottled with shades of red. The incidental appearance is due to the presence of opaque-white specks, spots, and streaks, which are generally known, since the publication of Balser's article, by the term fat-necrosis. These were seen in six of the cases, and it is not improbable that the granular exudation described by Löschner may have been of the same nature.

The pancreatic duct may contain a bloody, ichorous fluid, and its branches may be plugged with clotted blood. The duodenum and jejunum may show swelling, injection, and ecchymosis. The hemorrhagic infiltration may be found beyond the pancreas, both in the parapancreatic tissue, mesentery, meso-colon, and in the omentum. It may extend downward behind the descending colon, near to Poupart's ligament, and may be found at the outer border of the left kidney. The splenic artery and vein are usually free from changes. The latter may contain a thrombus. The portal vein has been found free from thrombosis. The condition of the other organs is essentially negative. The heart may contain liquid blood, or a differentiated clot may be found in the right ventricle. The spleen may be small, with wrinkled capsule, or it may be slightly

enlarged and injected.—*Med. Record*, Feb. 23, 1889.

[The reader is referred to THE MEDICAL ANALECTIC, 1886, p. 544, where the Editor, after reporting Draper's cases, reports one of his own, which Dr. Fitz has evidently overlooked.]

Migration of Foreign Bodies.—The following case is reported by T. M. Winters, M.D., of Danville, Michigan.[1]

Mr. George P., aged sixty-two, called at my office October 23, 1888. He informed me that he had always enjoyed good health until about one year ago, when a very painful superficial swelling appeared in his left lumbar region. This disappeared in a few days, but at intervals it has returned and passed away. Each recurrence has been a little lower than the preceding. When I saw him he complained of a very painful "bunch" in the left groin. Examination revealed a hard, well defined swelling about the size of a hickory nut, directly over the femoral artery in the upper part of Scarpa'striangle. The swelling, presenting all the evidences of inflammatory suppuration, I advised incision, and obtaining his permission to operate, cut the tumor, and to my surprise removed a steel needle two and one half inches long, nearly one eighth of an inch in diameter. He had no knowledge of, and could not account in any way for, its presence.

He consulted his mother, a very old lady, on the affair the day following, who says that when he was about one year old he swallowed the needle, and as it never caused him any trouble no importance was attached to the accident.

Dr. J. B. Greene reports[2] the following case:

Some time during the winter of 1885–6 I was called to see the three-year-old son of Mr. Henry Cook, of this place. I found the child busy with his toys, and not complaining of any thing. His mother informed me that while creeping over the floor he had suddenly cried out, and going to him she found a needle protruding, *point out*, from the inner aspect of the knee. I made a careful examination, and, aside from a small prick-point of the skin, I found nothing to indicate any foreign body being imbedded, and so informed Mrs. C. She said she knew it was there, for she had, in her effort to remove it, broken off the point. As the child suffered no more, I advised that nothing be done. I heard no more from the case until January 1, 1889, when the child was brought to me to examine a tender spot in the lumbar muscles, about 1½ inch to the left of the spine and about 3 inches above the crest of the ilium. I found a slightly darkened spot, and the "feel" indicated some foreign substance to be enclosed. Upon cutting through the skin I removed a piece of a needle 1 inch long, with the eye perfect and point gone.

Dr. D. W. Beard reports[3] a very interesting case:

In the afternoon of January 19, 1889, Miss S., aged eighteen years, was taking a lesson in dancing. While moving over the floor to the strains of the waltz music she was suddenly seized with the most violent excruciating pain in the right iliac region. She was carried into the adjoining room in an unconscious condition. The lookers-on describe her appearance as terrible and alarming. After the lapse of ten or fifteen minutes a transfer was ordered, and by a slow process of movement she was conveyed to her home. I saw her at six P.M. lying upon a lounge, with her limbs so decidedly flexed upon her body that I at once suspected either peritonitis or hernia. She could not be touched, her pain was so intense. I insisted upon the removal of her clothes and the placing of hot poultices over the abdomen, gave ¼ gr. morphia internally, directing the mother to send for me after she had been placed in bed, and especially if any evidence of a swelling was visible. I was summoned to her home at eight P.M. Immediately over the ileo-cæcal region I found a small prominence, which to the touch evidenced a foreign body. In moving the finger downward a sense of relief was imparted to the patient, and any movement in the opposite direction gave rise to intense pain, with loud screams from the patient. The proof seemed so positive that we had a foreign body, and its prompt removal was beyond any doubt, that I at once began a series of questioning as what it might probably be.

The patient had no knowledge of ever having swallowed any thing like a pin or a needle—was positive no needle had ever entered any part of her body. The location left no doubt in my mind that it was

[1] *Physician and Surgeon*, Jan., 1889.
[2] *Jour. Am. Med. Assn.*, Feb. 9, 1889.
[3] *Jour. Am. Med. Assn.*, Feb. 16, 1889.

evident that it had escaped from the bowel. If this surmise was correct, what did it mean—certainly a great risk of traumatic peritonitis.

The patient was placed under the influence of chloroform, the necessary details of antisepsis were brought into requisition, and after making an incision, immediately over the projection, through the fatty tissue, and gentle manipulation with a pair of forceps, a portion of a needle was withdrawn—black and thoroughly corroded—measuring 1⅛ inches in length. The wound was sutured, dressed antiseptically, and the patient placed in bed.

The patient had ⅛ gr. morphia, with ¼ gr. of calomel, every two or three hours, as required. No bad symptoms supervened, and the wound healed kindly.

The Tubercle Bacillus.—A French contemporary gives a vivid description of the vitality of the bacillus of tubercle. Of all micro-organisms it is one of the most refractory to the action of the most destructive agencies. It maintains its virulence after lying for forty days in putrid sputum, and for 186 days away from contact with air. It can live at temperatures between 86° and 104° F. The most unfavorable conditions, though affecting its activity, do not compromise its existence, for it resumes its virulence whenever its surroundings become suitable. To render it inactive it is necessary to have recourse to violent means, such as ebullition, steaming, or prolonged contact with antiseptic substances, such as ammonia, concentrated salicylic acid, absolute alcohol, or a strong solution of carbolic acid. Corrosive sublimate itself is said to be powerless to disinfect the sputum. The bacillus acclimatizes itself amid the most unfavorable surroundings. It complies with the exigencies of its condition, and even alters its shape, but without losing any of its virulence, of which it gives ample evidence whenever fortune favors it. Its polymorphism is not the least curious point in the life-history of this organism. Thus it is sometimes a short rod, sometimes a line—occasionally it splits and forms spores—but it always returns to the bacillus in its complete form, with its virulence intact, whenever circumstances become favorable.—*Med. Press*, Feb. 6, 1889.

Owen (E.) on Transplantation of Testis.—L. C., aged two years and seven months, was admitted on Sept. 28, 1888. The child is small for his age, and is unable to talk, but his limbs and head are well formed. On examining the genital organs, the right testicle was found well developed, and in the usual situation; the left testicle was also of normal size, but was situated in the perineum, to the left of the median raphe; the cord of the left testicle was apparently as long as that of the right, as the two organs were on a level with each other. The left half of the scrotum was small, and drawn over to the right side. On Oct. 3d Mr. Owen made an incision over the left half of the scrotum, through which the misplaced testicle was reached, and freed from adhesions. There was no difficulty in placing the gland in the scrotum; but, as it obstinately slipped back to its original position, a deep suture was passed from one side of the left scrotum to the other, behind the testicle, which effectually maintained it in its new position. The edges of the wound were drawn together by a continuous suture, and drainage was provided for by a narrow piece of tissue inserted at the lower angle of the wound. The wound united readily, except at one spot, where a very small slough separated, and when the child quitted the hospital, a fortnight later, the left testicle appeared quite natural. The child has since been inspected, and the result of the operation has, apparently, left nothing to be desired. —*Lancet*, Feb. 9, 1889.

Cirrhosis of the Liver in Cats.—Professor Greenfield reports (*Jour. Comp. Path.*, Dec., 1888) the results of his examination of two well-marked examples of hepatic cirrhosis in cats. In the one specimen the organ was much enlarged and smooth, resembling to the naked eye a leucocythæmic liver. Microscopically, however, the lobules were found to be separated by wide bands of connective tissue, within which were dense plexuses of young bile ducts and bile capillaries, the formation of which appeared partly to be formed by fission of the liver cells. In the other case, a successful injection of the bile ducts revealed a large number of such plexuses, and a comparison with a healthy liver proved that in the cirrhotic the plexuses were of new formation. Each animal had ascites, and the cirrhosis was monolobular. Professor Greenfield points to the similarity in anatomical character between the conditions here found and those met with in hypertrophic or "biliary" cirrhosis, the

difference being that in these cats there was no evidence of obstruction of the duct, or any jaundice, whereas there was marked ascites. In man hypertrophic cirrhosis is characterized by pronounced jaundice, and ascites is usually absent or slight.—*Lancet*, Jan. 12, 1889.

Ratton (J. J. L.) on Local Irritation by Ptomaines.—A clerk, aged 23, working in the cheese department, wiped his left eye lately with his finger after handling a ripe Stilton. Presently he felt a severe pain in the eye, "as if there was a fly in it," and the conjunctiva swelled rapidly so as to overlap the cornea all round within an hour. I saw him in this state.

The subconjunctival tissue was evidently distended with fluid; there was some pain and redness, but no photophobia, and nothing else wrong. I applied a saturated solution of borax, with a drop of atropine in it, as an antiseptic, and told him to keep the eye closed, as the pressure of the lids would cause absorption. In about another hour the eye was well.

This is his second dose of cheese-ptomaine in the eye. Three weeks ago the other eye was poisoned in the same way by a Gorgonzola. The swelling and subsidence were equally rapid. At that time no other treatment but fomentation was used. —*Br. Med. Jour.*, Feb. 2, 1889.

THERAPEUTICS.

Fatal Case of Cocaine Poisoning.—It was intended to wash out a man's bladder wtth a detergent astringent solution, and to deaden the sensibility of the pain a solution of cocaine was to be first injected. The two prescriptions, the one for the cocaine and the other for sulphocarbolate of zinc, were written on the same paper. The former simply directed that twenty grains of cocaine were to be dissolved in one ounce of water, and to it was appended the word "*statim*," without an accompanying verb to make the term intelligible. It was this defect which primarily led to the mistake which cost the deceased his life. The house surgeon wished to convey by the word "*statim*" that the solution was to be *dispensed* immediately. The dispenser, misled no doubt by the meagreness of the directions, misinterpreted it, and, believing the solution to be a *draught* for the patient to take, put it in a measure-glass and gave it to the nurse who waited for it. The latter administered it to the patient at once. What the initial symptoms were is not known, for it was not until nearly an hour had elapsed that the nurse, hearing the patient making some unusual noise, had her attention drawn to him. It is said that there was some arching of the back resembling the opisthotonus of tetanus, and that there was a convulsive movement of the limbs. Consciousness was to some extent retained almost up to the fatal issue, since the patient, although apparently insensible, could be roused sufficiently to say: "I sh'an't," in answer to an injunction to do something. Death took place in about an hour after swallowing the cocaine solution.

The post-mortem examination was made about twenty-six hours after death. There was nothing unusual to remark in the external appearances. Dissection revealed that the deceased had been the subject of old and recent tuberculosis of both lungs. There were numerous acute tubercular ulcers over the base and posterior wall of the bladder. The left kidney had been entirely destroyed, and its place was occupied by the remains of the shrunken capsule, in which were three small calcareo-caseous nodules. The left ureter was atrophied, its lumen apparently diminished except for about the lower inch and a-half, where it was dilated into a sac large enough to receive the end of the forefinger. The left ureteral orifice, as seen on the surface of the bladder, was enlarged, but the communication between the ureteral canal and the bladder could not be made out. The right kidney was hypertrophied—physiological. In it was a mass of breaking-down tubercle. There were dilatation of the calyces and well marked pyelitis. The ureter contained about a dozen recent small tubercular ulcers. Its lumen was widened, and contained a small triangular-shaped calculus—not impacted. The bladder was about half full of urine, not mixed with blood. The urine contained about one eighth part of albumen. This was accounted for by the muco-pus formed in the bladder, the ureter, and pelvis of the kidney. The liver showed well-marked cirrhosis—not cardiac. The spleen was enlarged, as a result of the portal obstruction. There was no ascites. The lungs were congested. None of the cavities of the heart were contracted, nor were they markedly dilated. They all

contained blood-clot. The valves were healthy. The brain was congested, and there was some serous effusion beneath the arachnoid, but there was no increase in the ventricular fluid. The stomach contained some thick pultaceous matter, mixed with mucus. Its mucous membrane showed hypostatic congestion at the cardiac end. The venous radicles were distended, evidently from the cirrhotic obstruction in the liver. The surface of the mucous membrane generally showed none of that minute injection of the vessels suggestive of the action of an irritant.

As the maximum officinal dose of cocaine is one grain, there can be no doubt that deceased took what would in most cases be a lethal quantity, although in one instance twenty-three grains and a half were swallowed without fatal results. The deceased was, unfortunately, so crippled in his renal function that a serious obstacle was presented to the elimination of the poison. As in other recorded fatal cases, death seems to have occurred partly from cardiac and partly from respiratory paralysis.—*Lancet*, Feb. 9, 1889.

Stedman (H.) on the Unusual Effect of a Full Subcutaneous Dose of Cocaine.—The patient, a middle-aged man, and fairly well nourished, but whose heart was weak and irregular, no actual murmur being detected, was admitted for recurrent cancer of the upper lip. Owing to the condition of the heart it was decided to use cocaine locally, of which ten minims of a 5 per cent. solution was injected on either side of the part to be excised, making one grain in all. The patient very soon became somewhat excited, and complained of "feeling queer," the respirations at the same time becoming rapid and shallow, and the pulse quick and feeble. This condition gradually became worse, until about twenty minutes after the administration of the drug the pulse-rate was 160 beats per minute, and was scarcely perceptible at the wrist, although the carotids were felt to be pulsating strongly. The respirations were very rapid, shallow, and irregular, with an occasional deep one, more resembling a sigh. The patient appeared to be panting for breath, but unable to satisfy himself, until suddenly he would manage to take a deep inspiration, and would then seem relieved, but only for the moment, when the same condition would rapidly return. He was totally unable to control his breathing momentarily in order to take an inhalation of sal volatile. The pupils were normal, and reacted well to light. There was marked cyanosis, especially noticeable on the lips and forehead. The feet became cold, and the skin covered with a clammy perspiration. As soon as the pulse showed signs of marked enfeeblement he was given a draught of sal volatile, but with little effect; he was then given a hypodermic injection of twenty minims of ether, which revived him considerably and greatly improved the vigor of the pulse, but only for a short time. These hypodermic injections were repeated three or four times at intervals of six or eight minutes, when the effects of the cocaine began to pass off. In about an hour and a half he seemed quite himself again, the respirations becoming quiet and easy and the pulse full and strong, but still remaining at 112 beats per minute. He was then given brandy and the operation was proceeded with, from which he has made a complete recovery.—*Lancet*, Feb. 9, 1889.

Magnan and Saury on Three Cases of Chronic Cocainization.—The predominant symptom was an hallucination of general sensibility, consisting of a sensation as of foreign bodies under the skin. One patient scraped his tongue, imagining it infested by little black worms; he also dug about in all his abscesses to eradicate "the germs of cholera." The second patient, a druggist, burned his skin and dug out the base of the wound to remove the "microbes" with a nail or needle. The third patient, a physician, persevered in searching for "crystals of cocaine" beneath the skin.

Hallucinations of sight, hearing and smell appeared later. They were much less active than those from absinthe or alcohol.

Analgesia was not very marked in these three cases although one had, without much pain, introduced a knife and some needles into the rectum.

One of the patients suffered from cramps and the other two had epileptiform attacks which did not occur after the drug was stopped.—*La Tribune Méd.*, Feb. 3, 1889.

Mayne (N.) on Turpentine in Post-Partum Hemorrhage.—For some years I have used spirit of turpentine in post-partum hemorrhage, and in every case with the best results. When the ordinary means—*i. e.*, friction over the uterus, irri-

tation of the uterus by introduction of the fingers, cold, hypodermic injection of ergotinine, etc.—failed, by saturating a piece of lint with the turpentine, and introducing it in my hand into the uterus and holding it against the walls, rapid contraction took place, and all hemorrhage instantly ceased. In one or two cases, when the patient was almost pulseless, it seemed to act as a stimulant. On no occasion did its action fail or did it cause the slightest inconvenience, except in one, when the side of the patient's thigh was slightly blistered by some that came in contact with it, but it gave very little annoyance. I consider it is much quicker and surer in its action than any other remedy ; and does not cause any injurious result, and is much more easily applied. In country practice, getting hot water or using injections often means loss of valuable time.—*Lancet*, Feb. 9, 1889.

Lawrence (S.) on Venesection in Puerperal Eclampsia.—The patient was a primipara—a case of twins—in which every thing passed off in the most satisfactory way. It occurred several miles distant in the country, the patient, whom I had not previously seen, to all appearances a perfectly healthy woman. Within an hour and a half after delivery, when I was just about to leave the house, I was hastily recalled to the room where the confinement had taken place, and found the patient had been suddenly seized with a most violent convulsion. I had her at once placed in the sitting position in bed, opened a vein and withdrew from 15 to 20 ounces of blood, with this result, that in a very short time convulsions ceased, consciousness returned, and from that hour her recovery satisfactorily progressed.

Whatever views may be entertained regarding the etiology of this grave complication of labor, or the value of other remedial agencies in its treatment, the decided efficacy of blood-letting in controlling and checking it can hardly admit of question. It might perhaps be easy, on the ground of modern theories, to show how this cannot be, but facts are stronger than theories. Our obstetric forefathers did not vacillate on this important question. Very possibly, considering that they lived in the era of too free and indiscriminate blood-letting, they may have pushed the practice of venesection in cases of eclampsia to too great a length ; but that they used the right weapon wherewith to combat a very serious malady I do not for a moment doubt. Chloroform and bromide of potassium in their application to such cases are new comparatively, and of much value no doubt, but to make them substitutes for judicious venesection, instead of its allies and subordinates, in cases of eclampsia, would, I am thoroughly persuaded, be to commit a grave mistake. The advocates of this high opinion regarding venesection find themselves in good company as they survey the roll of eminent obstetricians of a bygone age.—*Br. Med. Jour.*, Feb. 9, 1889.

Corney (B.) on Citrate of Caffeine in Eclampsia.—A woman of twenty-three gave birth to an undersized but full-time child at 7 A.M., August 21st, after an easy labor of three hours. About noon headache came on, at 9 P.M. vomiting took place, and at 11 P.M. convulsions set in, lasting, with intermissions, ten hours. The bromides, hyoscyamus, chloral hydrate, and chloroform did not seem to have much effect.

The patient remained in a deep stupor for three nights and the two intervening days. There was slight fever, a weak pulse varying from 80 to 132, great cyanosis, incontinence of urine, and left hemoplegia.

As the vital powers appeared to be rapidly failing, it was urgently necessary to take some decisive step. I objected to alcohol, because of the imperfect aëration of the blood that was going on, as evinced by the cyanosis. I was uncertain how much of the stupor and cardiac weakness was due to the disease, and how much to the bromide and chloral. Caffeine suggested itself, and I immediately injected grs. iii. of the citrate dissolved with grs. iiss. of sodium salicylate in M x. of distilled water. This was followed in an hour by six grains more given by mouth, and two grains every two hours afterwards for six doses.

Some general improvement took place, the pulse bettered, and the attacks of lividity ceased. The paralytic symptoms diminished in degree, and towards dawn on the 24th signs of returning consciousness were observed.

The caffeine was continued for two days, and from this time the patient made a steady recovery. A week later the only remaining abnormalities were a certain degree of muscular weakness and debility.—*Practitioner*, Feb., 1889.

Shaw (L. E.) on Hemorrhage in Salicylism.—For a woman of twenty-seven, with acute articular rheumatism, 20 grains of salicylate of soda were given every three hours, and, the symptoms improving, on the fourth day the same dose three times a day. At this time the patient was suffering from tinnitus, deafness, and hallucinations of hearing. Three days later profuse bleeding from the nose and gums began, and continued with varying severity for four days, large clots collecting in the mouth, and the fæces being blackened by changed blood.

Local applications were made of tannic acid and ice, and internally a mixture of witch-hazel and perchloride of iron was given. The scorbutic appearance of the condition led to the administration of lemon-juice.

The bleeding stopped when the salicylate was omitted, and recommenced when the drug was resumed. The patient had never had bleeding from the nose or gums before.

In another patient, a man of twenty-six, salicine was substituted for the salicylate of soda, and an exudation of blood, drying into the form of scabs, took place from the gums, tongue, and palate.

Altough the author has carefuly watched these cases for some years, he has never observed epistaxis or any other hemorrhage occur until several hours, and generally not until some days, after the more common symptoms produced by too large a dose have been well marked. These symptoms are deafness, headache, vomiting, tinnitus aurium, and an irregular and slow pulse, this being the order of frequency with which they occurred in a series of 174 cases. It would therefore seem that if due regard were paid to these indications that the drug is beginning to produce its physiological effects, and an appropriate alteration made in the dose, the occurrence of loss of blood, which the patient can so ill afford, might be prevented.—*Lancet*, Jan. 19, 1889.

Bowlby (A. A.) on Poisoning from Iodoform Used as a Surgical Dressing.—In a boy, aged eleven, whose knee-joint had been excised, and whose wound had been dressed with iodoform, the symptoms were acute and transient. A few days after the operation the temperature rose, the pulse became quick and a little irregular, and he very soon became comatose. His condition was in every respect similar to that of a child with tubercular meningitis. He lay on his back, with the head slightly retracted, the eyelids partly raised, showing the whites of the eyes, and uttering a low moaning noise. He was quite unconscious. The sudden onset of the symptoms, the absence of previous vomiting or headache, and the rapid rise of temperature, all, however, pointed to the possibility of iodoform poisoning, rather than to the supervention of tubercular meningitis, and although the child seemed actually moribund, he rapidly recovered after the iodoform dressing had been removed and the wound well washed out. In twenty-four hours he was practically well.

In another case the symptoms were insidious. A woman, aged fifty, had suppuration about the breast, which was treated by free incision and iodoform dressings. She soon became light-headed, and constantly talked nonsense, and, though never violently delirious, she gradually became worse. Her temperature was raised, her pulse rapid and feeble, and she was unable to sleep. The case occurred some time ago, and was not recognized at first as one of iodoform poisoning; but, as the wound was not doing well, the dressings were changed, and the patient quickly improved, only to again become fatuous when iodoform was again employed. This time, however, the onset of the symptoms was too evidently connected with the use of the drug, and on its being discontinued she made a complete recovery.

In a third case, one of amputation of the breast, the symptoms of poisoning took the form of a violent delirium, with almost complete inability to sleep, rise of temperature, and great mental excitement. In this case the iodoform dressings were at once discontinued, but without influencing the symptoms. The patient gradually became weaker, and, although she lived for three weeks, she sank and died without again becoming completely conscious. A necropsy revealed nothing which would account for the symptoms.

I have seen several other cases in which the patients at no time appeared to be in any danger of their lives, and in these a condition bordering closely on lunacy continued for several weeks in spite of removal of all iodoform from the wound.—*Lancet*, Feb. 9, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRUGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

With the active collaboration of

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LEADING ARTICLE.

Diphtheria. — Recent literature has been rather more than usually prolific upon the ever-fruitful theme of diphtheria. It has been wisely said that diphtheria presents itself to the physician in three types: cases that would recover without any treatment; cases that will be fatal in spite of the most skilful treatment; and cases in which treatment may change the termination from death to recovery. Unfortunately, with our present human limitations the physician cannot be sure to which category his special case may belong; so that it becomes his duty to treat every case as one of the third class.

Dr. Abraham Jacobi[1] has recently added another valuable paper to his previous writings on diphtheria. The author urges most strongly his claim for preventive treatment, of isolation for the sick, of separation of the well children of the family from other children, of instructing school teachers now to examine throats, of occasional inspection of the throats of servants, and of inspection and disinfection of public places and vehicles. Prevention for the individual is most successfully secured by keeping the mucous membranes of the upper air passages in a healthy condition. Large tonsils should be excised, operations upon the mouth during an epidemic should be postponed, and the presence of glandular swellings around the neck must not be disregarded. If every eczema of the head and face, every stomatitis and rhinitis, from whatever cause, were relieved at once, most of these glandular swellings, would be avoided. The author believes that all attempts at forming indications for the treatment of patients with diphtheria, based upon the preconceived or acquired idea as to the nature and causes of diphtheria, are all futile. While there are certain indications resulting from the characteristics common to all types of the disease, every case must be treated on general principles, which must be applied to the prominent individual features. Elevation of temperature, convulsions, vomiting, quick and feeble pulse, are symptoms to be met with all the tact of the skilled physician. The complications that arise, especially the usual signs, are to be treated on the principles acknowledged best for those conditions.

The local treatment of the pseudo-membrane the author considers of great importance. He believes that to regard the false membrane as an excretion which needs no interference, is incorrect. Whatever is done to the membrane must be done without violence of any kind. Applications to pharynx or tonsils made without proper leisure and accuracy may scratch off or change the epithelium surrounding the diphtheritic spot and thus favor the spread of the deposit. If nasal injections be found advisable, they can be made to wash the posterior pharynx and tonsils sufficiently so that applications through the mouth may

[1] Jacobi: Therapeutics of Diphtheria. *Transactions Phil. County Med. Soc.*, May 23, 1888.

not be necessary. Moreover, this nasal application is easier, meets with less objection and gives rise to less exhaustion than the forcible opening of the mouth. Where it is possible to make local applications without difficulty, tincture of iodine may be applied several times daily, or a drop of rather concentrated carbolic acid. Of powders, the author considers calomel the only one not absolutely contra-indicated. Every thing dry irritates and gives rise to cough or discomfort. Moreover, whatever has a bad taste or odor, as sulphur, iodoform, or quinia, should be avoided in local applications. For the purpose of dissolving membranes, papayotin or trypsin in solution may be injected, sprayed, or brushed on the affected tissues.

The inhalation of steam helps to loosen the membrane where it is not too firmly coherent with the surface beneath. In such cases steam may favor the extension of the process by softening the hitherto healthy mucous membrane. Steam may properly be mixed with medicinal vapors. The secretion of the mucous membranes is sometimes quite abundant under the influence of steam, and is also increased, like that of the skin, by the drinking of large quantities of water.

The treatment of diphtheria of the nose consists in persevering disinfection of the mucous surface. Disinfectant injections must be continued every hour, for one or more days. If they are well made, the consecutive adenitis is soon relieved and the general condition improved. Where the whole cavity rapidly fills with membranous deposits injections are unsuccessful and forcible treatment is required. A probe dipped in carbolic acid or wrapped in absorbent cotton, moistened with carbolic acid of 50 or 90 per cent., must be pushed through the mass until the injection can be used. The author enjoins upon the physician the importance of seeing that the nurse makes the injection properly, and of insisting upon her telling him at every visit that the fluid returns through the other nostril, or through the mouth, or is swallowed.

Besides sepsis, the two great dangers to be met in diphtheria are heart failure and strangulation. The danger of heart failure may set in at an early period of the disease, and must be constantly guarded against. Absolute rest and quiet are essential to the safety of the patient. The fatal results from excitement, sudden changes of posture, or from exertion, are but too familiar. Digitalis, strophanthus, spartein, besides camphor, alcohol, and musk, must not be postponed till feebleness and collapse have set in. The best internal stimulant, in urgent cases, is Siberian musk, in powder or in mucilage.

Paralysis during convalescence, or intense anæmia long after apparent recovery, have their distinct indications for treatment.

In regard to the internal medication for diphtheria, the author advocates, rather guardedly, the use of the chloride of iron and the bichloride of mercury. He thinks that children with naso-pharyngeal diphtheria, large glandular swellings, feeble heart and frequent pulse, intense sepsis, and irritable stomach, especially cases in which only large doses of stimulants, general and cardiac, can promise any relief, are better off without iron. The author's observations of the last four years incline him to modify his former conviction of the utter uselessness of internal medication in laryngeal diphtheria.

Dr. J. Lewis Smith[1] considers the pathology and treatment of sudden heart failure in diphtheria in a recent paper read before the New York Academy of Medicine. The author shows the improbability of many of the theories that have been advanced to account for this sudden heart failure. Endocarditis, granulo-fatty degeneration of the muscular fibres of the heart, and cardiac thrombosis, are dismissed as unsatisfactory explanations. The theory of deficient innervation, or a true cardiac paralysis, Dr. Smith thought the most tenable. In discussing the etiology of cardiac paralysis, the author considers it as identical in nature with other forms of paralysis after diphtheria, and he thinks that clinical facts seem to indicate that a ptomaine is the direct cause of the paralysis, especially in cases occurring early and quickly cured. But he considers that the marked degenerative peripheral and central nerve lesions so frequently present in those who have died with diphtheritic paralysis, prolong and intensify the paralysis, and are in some instances its primary cause. The treatment of cardiac paralysis requires prompt and active remedies. The patient must

[1] Sudden Heart Failure in Diphtheria. *Medical News* Philadelphia, Nov. 10, 1888.

be kept quiet, alcoholic stimulants administered—brandy in hypodermatic injections, ammonia, camphor, musk, and electricity. Strychnia is endorsed as an efficacious nerve stimulant in the various forms of diphtheritic paralysis.

Dr. G. E. Hubbard[1] records his results, which have been most satisfactory, with a solution of sulphuret of calcium, in the local treatment of diphtheria. The solution is prepared as follows: Of lime, one part; sulphur, two parts; water, twenty parts. Slake the lime with some of the water, then add the remainder and the sulphur; boil to twelve parts and filter. It occurred to the writer that if this solution was so effective in the treatment of scabies, it might serve a good purpose on the pseudo-membrane of diphtheria. Under the use of the solution in spray, the diphtheritic patches undergo a change in a few hours, in some cases disappearing entirely in a day. The writer believes that this solution does much towards preventing constitutional infection. Its stimulant, laxative, and somewhat diaphoretic and diuretic action are quite marked.

Dr. J. Henry Fruitnight[2] recalls the familiar fact that most of the remedies used with the intention of producing constitutional effects, also, to a certain extent, act locally, as the chloride of iron, the chlorate of potash, and the bichloride of mercury. The writer calls attention to the local action of hyposulphite of soda, a remedy which had been used in the past for its constitutional effect alone. The drug is administered in the strength of ʒ ss. to ℥ i., the dose ʒ i. every two hours. When the patient was too young to comprehend the direction to hold the dose in the mouth, and when the deposit is confined to the buccal cavity, the solution can be also used in the atomizer.

Dr. George B. Hope[3] believes that in peroxide of hydrogen will be found, if not a specific, at least the most efficient topical agent in destroying the contagious element of diphtheria and limiting the spread of its formation, and at the same time a remedy which may be employed in the most thorough manner without dread of producing any vicious constitutional effect. When uncertain results have attended the use of the peroxide, the writer claims that one or both of two reasons are the explanation. These are: first, that improper cases are selected for experiment; secondly, that the preparation is imperfect or its topical application ineffective. Inasmuch as the efficacy depends upon the ozonized oxygen in solution, Dr. Fruitnight uses the full strength of the officinal preparation of fifteen volumes. A steady coarse spray, with an air-pressure of twenty pounds or more, will, in a few moments' time, produce a more positive action than is accomplished by prolonged efforts to reach the fauces by means of cotton applications. The force of the spray should be sufficient to cleanse at once the surface accumulations. Immediately on contact with the peroxide a white, cloudy coagulum is formed on and about the diphtheritic patches, readily floated off and exposing a more sharply defined and a flatter, smooth, and whiter base. Properly speaking, there is no liquefaction of the exudation, but the decomposition of the inflammatory products is so complete that the cells are broken up and freed from the entangling net-work beneath. Two applications a day, in the great majority of cases, should be sufficient, if thoroughly performed, to arrest all danger of extension and accomplish the gradual resolution of the local formation.

Dr. Edgar S. Barnes,[4] of Eye, Suffolk, England, in an address before the East Anglican branch of the British Medical Association, has given some very interesting points upon the distribution and causes of diphtheria in England. The writer presents the results of his investigations (as a "Medical Officer of Health") in fifty separate outbreaks of diphtheria, extending over a period of thirteen years, and embracing 223 cases, of which 40 were fatal. The first point to which attention is called is the geographical distribution of diphtheria. The favorite habitats of diphtheria are different from those of scarlet-fever. Scarlet-fever, like most infectious diseases, is most prevalent and most fatal in districts containing the most dense population, with the single exception of London, where the facilities for isolating early cases hold the

[1] Hubbard: Local Treatment of Diphtheria by sulphuret of calcium solution, *N. Y. Med. Rec.*, Dec. 15, 1888.

[2] Fruitnight: Local Treatment in Diphtheria, *Arch. of Pediatrics*, Oct., 1888.

[3] Hope: Some Clinical Features of Diphtheria and the Treatment by Peroxide of Hydrogen, *N. Y. Med. Rec.*, Oct. 13, 1888.

[4] Barnes: Etiology of Diphtheria, *Brit. Med. Jour.*, July 28, 1888.

disease to some extent in check. Diphtheria, on the contrary, is most prevalent in the comparatively thinly populated districts of the southeastern and eastern counties of England, in Cornwall, Somerset, and North Wales, avoiding the populous manufacturing and mining centres, and the northern counties of England. The agency which favors the development of diphtheria in rural districts is probably the dampness of soil, caused by want of suitable systems of drainage, combined with filth in the form of decomposing animal matter. Dr. Barnes illustrates his paper by a colored map of England, showing the areas of greatest frequency of outbreak, the degrees of severity of the epidemics, the characters of the soil, and the density of the population. Some striking instances are related of the connection of filth and defective drainage with spread of the disease. The author also regards school attendance as one great agent in the diffusion of the infection. The writer considers the question of the bacterial origin of diphtheria as still in an unproved state, though for the sake of completeness he reviews the claims of the various bacteriologists. The writer remarks that, in other specific diseases, we never find a preceding period of an undeveloped disease, whereas, in outbreaks of diphtheria, it is not uncommon to find that sore throats have prevailed for some time previously, which have not presented the true characters of diphtheria. In three of the outbreaks which are recorded in this paper this was observed by the author. He adds that in other specific diseases—for example, small-pox, scarlet-fever, or measles,—such previous outbreak of nondescript cases is not observed. To the writer's mind this points to a poison gradually developed by insanitary conditions, rather than to a definite specific germ, be it bacterium, bacillus, or micrococcus.

ELIZABETH STOW BROWN, M.D.

OCCASIONAL REPORT ON GYNÆCOLOGY.

BY J. S. HAWLEY, M.D.

Taylor (Wm. L.) on Uterine Hemorrhage.—Any flow, either at or between the regular periods of menstruation, which exhausts the patient, can be considered a hemorrhage. At the occurrence of puberty and of the menopause, hemorrhage may occur, which only requires time for its relief. Hemorrhage is menstrual or intermenstrual—menorrhagia or metrorrhagia,—varying in extent from profuse menstruation to excessive flow from fungous endometritis, sarcoma, intrauterine febroids or cancer; slight intermenstrual oozing may be due to pelvic congestion. The most fruitful cause of uterine hemorrhage, in the experience of the author, is the presence of fungoid granulation of the endometrium, and a few of these are capable of causing excessive hemorrhage. The dull curette will remove these with little danger of evil effects, if antiseptic measures are employed, and the sharp steel instrument may be used if the growths are difficult of removal. It is well to dilate the cervical canal with a steel dilator before using the curette, for the purpose of providing for its free passage and that of an applicator, and for subsequent drainage. An application of carbolized iodine should be made to the endometrium after the operation.

If the hemorrhage be due to sarcomatous degeneration of the endometrium, serious hemorrhage may result, but the condition may usually be recognized by the fœtid, watery discharge, the cachexia, and the history. If not, the microscope will decide the character of growths removed by the curette.

Any cause of hyperæmia of the uterus will cause hemorrhage,—displacements, laceration of the cervix, fibroid tumors in the uterine wall, and malignant disease of the cervix, Emmet's "congestive hypertrophy," in which the uterus feels puffy, the cervical canal is everted and filled with granulations, which resemble those of epithelioma, and the cervix is swollen and livid. In such cases scarification and astringent applications, with the use of the tampon or pessary, are necessary to relief. Curetting should always be done in case of enlarged uterus, when fibroid tumors are found, or no malignant disease is manifest. In the former case the operation will relieve temporarily, in the latter more serious measures will be necessary. Lacerated cervix must be repaired; displacements of the uterus must be corrected by the use of the tampon and the pessary; the cause of the congestion of endometritis must be removed, if possible. Galvanism has not given good results in the author's experience; the curette has accomplished

what was required in a more rapid and satisfactory manner.

As to internal medication, ergot has given the best results, given in from one half to one drachm of the fluid extract three times a day; next in order, oil of erigeron, in capsules of five minims each, every three or four hours; digitalis nearly to its toxic effect, aromatic sulphuric acid, gallic acid, turpentine and tincture of cinnamon are also of value. The bromides are combined with these in cases of marked uterine and ovarian congestion.

Examination should be made early in cases of hemorrhage, without waiting for the cessation of the flow; remove constipation, portal congestion, mental causes, if possible, and do not meddle, above all, with an inflamed uterus, or maltreat into a state of inflammation one which is sympathetically in trouble.—*University Med. Mag.*, February, 1889.

Nagle on Disease of the Ovaries.—Oöphoritis is essentially interstitial, and healthy ova are produced for a surprisingly long time after the stroma of the organ is affected. After the process has reached a certain limit, the follicles wither and the functional activity of the ovary ceases. The atrophy is in some cases active, in others passive. One form of acute interstitial oöphoritis, a primary disease leads to the "hypertrophy with sclerosis," of some pathologists, in which the ovary may grow as large as a goose egg, and with a surface like that of a mulberry. Usually the disease is secondary to a circumscribed peritonitis. The author denies the existence of the chronic follicular oöphoritis of certain pathologists, believing the condition to be simply an individual peculiarity of the possession of an unusual number of healthy follicles, the condition of which is normal. He denies that a large follicle, lined with its usual epithelium, but containing no ovum, can develop into or take any active part in the development of a cystic tumor. He gives reasons for the conclusion that simple cysts of the ovary are usually due to cystic degeneration of the corpus luteum. The later stages of interstitial oöphoritis constitute an incurable condition, and justify removal of the organ; but an ovary simply enlarged, or with a cystic projection in its surface, is not necessarily morbid; nor is either condition one demanding its removal.—(Edit.) *Br. Med. Jour.*, Jan. 5, 1889.

Hewitt (Graily) on Anteflexion of the Uterus as a Cause of Repeated Abortion.—The author relates the history of a case in which two abortions had occurred before coming under his observation. The uterus had been anteverted, according to the report of the attending physician, Dr. Randall, during the second pregnancy. It was found anteverted and inclined to the left by the author at the seventh week of pregnancy, but rest and other careful treatment failed to prevent abortion, which occurred at the third month. The uterus was found to be enlarged and anteflexed after this, and was treated by dilatation of the cervical canal and a pessary, which lifted it in the pelvis. After a year or two the patient again became pregnant, and was seen at about the second month of gestation. There were premonitory symptoms of abortion—a colored discharge and pain, which were partially relieved by rest and the pessary. The uterus was found to project forwards and to the left, lying very close to the pubic bone. Pressure through the vaginal wall at this time always relieved the pain, and the use of the elevating pessary was continued until the time of quickening. The pregnancy went to term.

In cases of habitual abortion, in which the uterus is found to be retro- or anteflexed, the organ should be prepared for pregnancy by lifting the fundus and by dilating the cervical canal when the tissues at that point are contracted. Pain at a particular point in the pregnant uterus is caused by rigidity of tissue at that point. The lifting of the organ favors expansion, and thus gives relief. Only in cases of indurated tissue about the point of flexion is this treatment during early pregnancy necessary, as when the uterus is soft no trouble results. The same rules that apply to the treatment of retroflexion, in which the necessity of raising the fundus is generally understood, are to be made in regard to anteflection.—*Lancet*, Jan. 5, 1889.

Segur (G. C.) on Medicinal Treatment of Menstrual Disorders.—The management of such diseases without physical examination is often demanded of the physician in the cases of young girls, or others who will not submit to local treatment until driven to it by long continued suffering. The author's experience is given in the following résumé: *Ammenorrhœa.* General tonics, iron, arsenic, cod-liver oil.

The salts of manganese, particularly the binoxide, have given the most satisfactory results. The permanganate of potassium often gives excellent results, but like all compounds of manganese, except the binoxide and the lactate, causes too much gastric irritation to be of great value.

Dysmenorrhœa. The author has had best results from three- to five-drop doses of tincture of pulsatilla, cannabis Indica, viburnum, camphor, belladonna, and antipyrine. Binoxide of manganese has also done good service in doses of six grains *per diem*. Heat, as applied by douche or sitz bath, is a valuable adjuvant.

Menorrhagia. In this condition the most reliable remedies are ergot, hydrastis, digitalis, sulphuric acid, fluid extract of gossypium, and gallic acid.

The author gives a review of the opinions of many prominent gynæcologists on these subjects, and finds much lack of unanimity as to certain drugs, and finds that the number of remedies which are vaunted as useful in the treatment of any particular form of menstrual disorder is usually in inverse proportion to its amenability to treatment.—*Trans. Conn. Med. Soc.*, 1888, and *N. Y. Med. Record* (edit.), Feb. 2, 1889.

Treatment of Vaginismus.—Lutaud recommends, before resorting to operative treatment, to attempt the cure of this condition as follows: Introduce every night within the vulva a bougie composed of iodoform, gr. 15; extract of belladonna, gr. 7½; cacao butter, dr. 2½. Inject into the vagina three times daily a quart of hot water, to which has been added a teaspoonful of carbonate of soda, afterwards swabbing the vagina and vulva with a 10-% solution of hydrochlorate of cocaine. This treatment is to be continued for a month, and attempts at coitus are to be practised every two or three days after having anointed the vulva and penis with some lubricant. As parturition generally causes vaginismus to disappear, Lutaud advises that a hypodermic injection of ¼ of a grain of morphia should be given before coitus, as this, by its sedative action, may allow the act to be successfully performed, with pregnancy and the cure of the vaginismus as the result.—*Jour. de Méd. de Paris*, Nov. 18, 1888. Translation in *Canadian Pract.*, Jan. 16, 1889.

Schultze on Amputation of the Septic Body of the Uterus in Puerperal Disease.—A case of retained placenta in a bicornuate uterus, with excessive rigidity of the cervix, preventing removal, followed by septicæmia, was treated by amputation of the supravaginal portion on the sixth day after labor. The patient had suffered from chills, pyrexia, and all the ordinary symptoms of septicæmia. Upon abdominal section, performed after repeated efforts to remove the placenta had been frustrated by the rigid condition of the cervix, the uterus was found in an almost rotten condition, with signs of commencing peritonitis. The uterus was amputated, the stump being treated extra-peritoneally with an elastic ligature, the application of the actual cautery, and subsequent dressings with zinc chloride. Improvement was rapid and complete. The placenta was putrid, and the entire uterus infiltrated with purulent fluid. This procedure is proposed as indicated in cases in which there is no evidence of septic thrombi or emboli having been carried to distant organs, and in cases in which, like that reported, the removal of the placenta is prevented by a malformation of the uterus. —Translation in *Can. Med. Pract.*, Jan. 16, 1889.

Holmes (H.) on Fatal Vicarious Menstruation.—The patient lacked a few days of being seventeen years of age, weighed one hundred and twenty-eight pounds, and had never menstruated but once,—two months previous to this illness. She had never been considered a robust girl, nor yet a sickly one; had not a hæmorrhagic diathesis. For the last three years she had had copious epistaxis, but not at regular or monthly intervals. She had vomited blood once before in Feb., 1888.

The present attack was ushered in by the vomiting of a large amount of blood. The patient when first seen December 6th, was very restless in bed and delirious. She showed no distinct consciousness of her condition or wants; said she had no pain, did not know if she felt uncomfortable anywhere, thought those two young men (her neighbors) ought not to be in her sick-chamber with her; wanted water, wanted something to eat, wanted to go to bed, etc.

She was pale, with a pulse 110, so small I counted it with great difficulty. Her respiration was easy, and her lungs clear and resonant. Her abdomen was not distended, fairly full and soft, but not tym-

panitic. She had very frequent sighing, some yawning, with much jactitation.

During the two hours I remained with her she took very small quantities of oyster broth, milk, or water several times, with assistance to sit up in bed. She had not vomited for twelve hours; but in using the vessel some hours before I saw her, she passed a small quantity of blood, and a digital examination indicated that it did not come *per vaginam*.

She had taken scarcely any sleep or nourishment for more than twenty-four hours. Before leaving her I prescribed nourishment, stimulants, and opiates.

The patient's mother had consulted her family physician the 4th December, for something to bring on her daughter's menses, and again the 5th for something to stop her vomiting blood, which began at 2 o'clock that morning.

Her condition soon became more alarming, and before 11 A.M. I was called in hot haste; but she was dead within thirty minutes, and before I reached the house. She had sunk easily and gradually. No autopsy could be obtained.—*Boston Med. and Surg. Jour.*, Jan. 31, 1889. R. W. A.

Coe (H. C.) on Early Recognition of Cancer of the Cervix Uteri.—The majority of the cases of cancer of the cervix uteri do not come under the observation of the surgeon before the disease has progressed so far that it is impossible to perform a *successful* radical operation. The attending physician is too often responsible for this delay, although he is not entirely inexcusable for misinterpreting the initial symptoms.

The symptoms of incipient malignant disease of the cervix are seldom characteristic, but they are such as to awaken suspicion and to justify an examination. Slight, irregular hemorrhages, especially after coitus, are always significant, above all in women who have passed the menopause. Pain is seldom characteristic. There is no offensive discharge in the early stage.

Hypertrophy and general induration of the cervix, accompanying an erosion which bleeds easily to the touch, should lead the physician to confirm the diagnosis by excising a fragment of the suspected tissue and submitting it to microscopical examination.

A positive opinion regarding the presence of malignant disease is justified only by the finding of processes of atypical epithelium which *invade the subjacent muscular tissue*.

Excision of the cervix should be performed in every case of extensive erosion with general induration, whether cancer has actually developed or not. This is often sufficient to insure a cure, and thus to render a radical operation unnecessary. If the disease recurs, the uterus may be extirpated subsequently.—*Med. News*, Feb. 16, 1889. R. W. A.

CONCERNING EPIDEMIC PNEUMONIA, AND THE PATHOLOGY OF THE DISEASE.

By far the most important contribution to this subject of late is that of Dr. Thomas Darlington, of Kingsbridge, N. Y., who, in the winter of 1886, alone, saw more than one hundred and fifty cases of pneumonia among workmen on the new aqueduct.

He says[1]:

All of the workmen on the line were exposed to numerous causes predisposing to pulmonary disease. First, the tunnel was not well ventilated, and, as there were many workmen, the atmosphere became foul from their breath. Second, the kerosene-oil lamps in their hats smoked, and their mouth and fauces soon became covered with fine particles of carbon. Third, in the hard quartz-rock the steam drills produced a fine glistening powder which shone like diamond dust on the faces of the men as they came out. Fourth, from many crevices spring-water dripped constantly on their heads, shoulders, and chests. Fifth, poisonous gases were developed from the blasting of dynamite, and frequently so noxious were these gases that nearly a whole "shift" at once would be brought up asphyxiated. Sixth, from the warm tunnel (55° to 70° Fahr.), exposed to no drafts, the men would come up thinly clad, and wet with the drippings from the roof and perspiration, in mid-winter, to the surface, where the wind blew and the temperature was more frequently below 15° than above it. Nearly all were intemperate, few properly clad, and many had improper and insufficient diet.

All of the cases to which I refer were intra-alveolar (lobar) pneumonia.

At different shafts the disease manifested itself by different symptoms. There seemed to be no particular difference in the num-

[1] *Med. Record*, Dec. 8, 1888.

ber of cases by changes in the weather, whether muggy and warm with an easterly wind, or very cold, clear, and blustering, with a westerly wind, except in sporadic cases, which occurred principally in the very cold winter weather.

At Shaft 23, in February, I had twenty-five cases in ten days. In these cases the symptoms were practically uniform. All of them commenced with a chill, more or less severe, followed by a temperature from 101° to 104°. There was also slight jaundice, vomiting, spasmodic cough, some diarrhœa or dysentery, no delirium, but frontal headache, sweating—though in a few cases a dry skin,—an absence of or very little bile in the passages, which were extremely fetid in character. The patients complained but little of pain. The sputa was of various colors; it was in most cases of a light rust color preceded by jet-black sputa, composed principally of carbon from the lamps; and in some cases it continued to be more or less so colored to the end of the disease. In all of the cases there were symptoms referable to the liver, but whether these were due to previous alcoholism, or to the disease itself, I was unable to determine. Besides these symptoms there was also generally scanty urine. The vomiting was constant, and in most cases seemed to be watery material from the stomach. This epidemic occurred in one room of a large shanty in which eighty men slept, forty during the day and forty in the night. There were but two windows, and these were never open. The odor was that of a menagerie. The sputa and vomited materials went on the floor; these were covered with ashes or dirt and swept up. On the tenth day I had the room emptied, the sides and ceiling whitewashed, the bedsteads washed, the bedclothes and mattresses taken out into the sunlight and as much as possible washed, the windows opened, and the floor sprinkled with chloride of lime. Then the epidemic as such ceased abruptly. After this, cases occasionally occurred in this room, and in an annex building, where four or five occurred at once; but the same disinfecting and fresh-air treatment accomplished the same result. Some of the shanties in the neighborhood, particularly the darkies' quarters, became infected in the same manner.

At Shaft 24, the disease seemed to take a different type. There was little vomiting, no diarrhœa or dysentery, no sweating or jaundice, simply hepatization, dyspnœa, and symptoms of fever. Here there was no overcrowding in the boarding-houses, not so much smoke in the tunnel, and no water. Here, however, the rock was very hard and flinty in character, and the atmosphere in the tunnel was charged with fine particles of quartz. In these cases the predisposing, if not the exciting, cause was due to these.

At Shaft 20, the cases assumed still another type. These were largely among Italians. But few of these went to the hospital. Nearly all commenced with symptoms of pleurisy, and by the second or third day the inflammation extended by contiguity to the lung-tissue itself. Many of these men worked on the surface, and were often exposed to an icy wind that had a sweep for miles. Here also it was quite wet, and rheumatism was common.

The cause here seemed to be rheumatic, or prolonged exposure to cold. All of these cases made good recoveries. The shanties for the Italians were not as well built as for the other workmen, and to this I attribute partly the good results obtained. It was possible to see the daylight from the inside in any portion of the building, so that there was no lack of fresh air.

In a few isolated cases the disease evidently originated from injuries received to the chest. These cases involved invariably one lobe of the lung only.

In other cases the disease occurred immediately after intoxication and exposure all night on the ground.

In all of the cases the cough was peculiar and not entirely due to the pneumonia, but came from a neurosis or irritation of the pneumogastric nerve from poisoning of the gases set free in the explosion of dynamite. It was spasmodic in character and similar to a malarial cough or pertussis.

In some cases fatigue seemed to be either exciting or predisposing cause; which, I could not say.

Is pneumonia the manifestation of a systemic disease with a characteristic local lesion? or is it a purely local disturbance with constitutional symptoms? My experience leads me to say both. Looking at it in the epidemic form, and taking into consideration the fetid character of the passages, the diarrhœa, and symptoms referable to the liver, it seems to me that in some cases it is a systemic disease, while in other cases it certainly is not.

In the infectious cases the stage of incubation did not seem to be over forty-eight hours. Had the character of the discharges from the bowels any thing to do with the pneumonia? Did these occur from, or were they assisted in occurring by, the damming back of the portal system? or conversely? Certain I am that purgatives, particularly those of an antiseptic variety, such as mercury, used early in the disease, seemed to modify the course and symptoms greatly.

In regard to the treatment, I believe the less treatment the better. I never used aconite but once, and on that occasion the patient drank it all in one dose. And I did not give whiskey, for it would have disappeared immediately. I feel convinced that if we do not give much aconite, we will not have to use so much whiskey. And I firmly believe that whiskey, as a rule, should not be given, and that if a stimulant must be had, opium, in the form of Dover's powder, is much better. I made no selection of the cases that I kept, they were simply those who would not go to the hospital; but nevertheless I did not have a single death from pneumonia on the line. My treatment simply consisted of cathartics (principally pil. cath. co.), ammonia muriate with ipecac, and last, and of most importance, *fresh air*.

A very complete summary of the symptoms of epidemic pneumonia is given [1] by Dr. Edward F. Wells. He says:

There may be prodromata, with an insidious and prolonged invasion, or it may appear in the ordinary manner, or the access may be remarkable for its suddenness and impetuosity.

There may be an initiatory chill of greater or less intensity and duration, although this is lacking in many epidemics. The temperature curve may follow a higher or lower plane than ordinarily, or it may be very irregular in its course. The pulse may beat with great force and rapidity, or it may be weak, or it may be even slower and of greater volume and force than in health. Respiration may be very rapid and difficult, or it may be easy, regular, and natural. The breath may unaltered, or it may have a hot, foul, or a peculiar nauseous sweetish odor. Pain and cough may be present or absent, and when present may show striking peculiarities. Expectoration—not always present—may be hemorrhagic, muco-purulent, gelatinous, gangrenous, or so acrid as to corrode the mucous surfaces with which it comes in contact. Diarrhœa is a rather frequent symptom, and it may be colliquative, dysenteric, gangrenous, or fetid. Helminthiasis may be a marked feature. The urine may be excessive, scanty, albuminous, or hemorrhagic. The tongue may be clean and moist, foul and coated, or dark and dry. Sordes are often present. The abdomen may be painful and tympanitic. The mind may be clear or profoundly affected, as with melancholia, apathy, delirium, sopor, or coma. Convulsions are not uncommon. Jaundice has been often noticed.

In some outbreaks the type of the disease has been sthenic, and in others asthenic, or it has begun in one form and changed to the other. In some the local, and in others the general, symptoms were most prominent. In some the local inflammation passed on with the utmost rapidity to the total destruction of tissue, and in others there has been a late localization of the disease, or the pulmonary lesion was even unsuspected during life. In some the local affection was of the most transient nature, whilst in others it was very persistent. Sometimes the local disease was quite migratory and erratic in its course and at other times it, and the general symptoms as well, was distinctly remittent or intermittent in its progress. Hemorrhages and various eruptions have been frequently noted. Inflammatory and gangrenous angina, scurvy, abscesses, splenic enlargement, hepatic and nephritic changes, cardiac degeneration, endocarditis, pericarditis with hemorrhagic or purulent effusion, pleuritis with similar effusions, inflammation and gangrene of the stomach and bowels, meningitis, mental aberrations, etc., have all been frequent epiphenomena in various epidemics.

The duration and prognosis will vary so much with the character of the epidemic that no trustworthy generalizations can be made. It can only be said that the malady may be so mild as to be almost insignificant, or it may be so virulent as to constitute a disease of the greatest fatality, rivalling, in this respect, any other.

The lesions found after death have also varied greatly in different epidemics. In some it is the pulmonary tissues which

[1] *Jour. Am. Med. Ass'n.*, Feb. 26, 1889.

alone, or mainly, bear the brunt of the disease, whilst in others the bronchi or the pluræ are principally affected, the inflammation of lung substance being of secondary importance. In some the local affection has proceeded with wonderful rapidity to complete consolidation, or even destruction, whilst in others this was effected more slowly, and in yet others it never occurred—the morbid action not passing beyond the state of engorgement and stasis, or if, perchance, an attempt at exudation had been made, the interalveolar exudate was gelatinous and non-plastic. The limits of the local morbific process may be lobar, or it may be diffused and with no distinct line of demarcation. The pleura and pericardium are very often affected, with a tendency to early and extensive effusion, which is very likely to become purulent. The blood is sometimes dark, thin, and non-coagulable, and at others there is a peculiar tendency to the formation of heart clot.

Besides the strictly pulmonary lesions one may meet, as a part of the epidemic, the lesions peculiar to cerebral and spinal diseases, enteric and puerperal fevers, dysentery, erysipelas, rheumatism, scurvy, diphtheria, measles, variola, scarlatina, pertussis, enteritis, duodenitis, hepatic and nephritic diseases, etc.

In some epidemics resolution occurs promptly and completely, whilst in others it does so but slowly, irregularly, and incompletely, or there may be a strong tendency for the inflammatory action to pass on to chronicity, abscess, or gangrene.

The direct etiological bearing of the two micro-organisms found associated with croupous pneumonia is still undetermined. The more conservative pathologists are inclined to lay greater stress upon predisposition than the mere presence of germs, which so far have not been proven to have any causative relation to the disease.

Dr. William H. Welch says[1] of Friedländer's bacillus: "In *my* judgment it has not been satisfactorily demonstrated to be in any case the cause of genuine croupous or lobar pneumonia of *human* beings."

Of the second pneumo-coccus—the micrococcus Pasteuri of Sternberg, sometimes called Fränkel's pneumo-coccus, the same authority says:

"It is present in the exudation and the sputum of croupous pneumonia far more frequently than is Friedländer's bacillus . . .

"It must be admitted that the evidence in favor of the micrococcus Pasteuri being the cause of croupous pneumonia is *stronger* than that in support of Friedländer's bacillus, but it does not seem easy to reconcile with this evidence the fact that the micrococcus Pasteuri has been found in a variety of conditions not associated with croupous pneumonia, viz.: in the normal saliva, in lobular pneumonia, in cerebro-spinal meningitis, in acute endocarditis, and in otitis interna. If this organism be regarded as the cause of these various diseases, as well as of croupous pneumonia, the croupous pneumonia loses much of its typical or specific character. . . .

"It is apparent that the evidence is not conclusive that either of the organisms is the infectious agent of croupous pneumonia, certainly no such evidence has as yet been presented as that which leads us to accept the tubercle bacillus, the typhoid bacillus, the cholera spirillum as the cause of the respective diseases in which alone each of these organisms has been found."

[1] *Jour. Am. Med. Asso'n*, July 28, 1888, p. 114.

MISCELLANY.

Curtis (G.) on Gangrene of the Lower Extremities Following a Blow on the Epigastrium; Double Amputation.—A. Krooman, aged twenty-eight, was received into the hospital August 4, 1888, suffering from gangrene of the lower extremities, the line of demarcation being well formed in each in an irregular ring from four to six inches above the malleoli; pulse 80, weak; body temperature ranging from 100.4° to 103° F.; gangrenous parts very fetid, covered with bullæ, swollen, and crepitant to touch.

The above condition resulted from stoppage of circulation of the parts, which came on rapidly, accompanied by intense pain, on emerging from a state of relapsing syncope caused by a severe blow by a capstan bar on the abdomen July 10th.

Amputation being inevitable, I removed both legs under chloroform on August 6th, about eight inches from the knee. Long and broad flaps were used in front and short behind, and the crests of the tibiæ bevelled off. The resulting stumps are neat and sound; the line of cicatrix being behind and above the end of the bone,

leaves the limb well adapted for the "kneeling pin."

The *rationale* of the process of gangrene set up simultaneously in both feet after a blow of the abdomen is not self-evident. This man has a rather weak pulse, but the heart-sounds are normal; he is a native of the tropics, entering suddenly into a temperate and comparatively cold climate, and was liable to chilled feet by washing clothes on a lead flooring; and these circumstances may have predisposed to blood stagnation of the extremities. But the efficient cause of gangrene was plainly the severe blow on the epigastrium, and the subsequent chain of events seems to have been—shock of the sympathetic system, through the sudden contusion of the solar plexus and splanchnic ganglia, etc. (analogous to the spinal cord); relapsing syncope of heart, with general vasomotor paralysis and stasis of blood in the remote vessels. The blockage of the tibial vessels seems to have been too great for the returning circulation, and local death ensued.—*Br. Med. Jour.*, Feb. 16, 1889.

Thacher (J. S.) on Tricuspid Stenosis.—A woman, twenty-nine years of age, had been married six years, and had had two miscarriages but no living children. There was no history of rheumatism, but the patient had had scarlet-fever in childhood. She had had leucorrhœa for a number of years. There was no history of syphilis. Five months ago she had some swelling of the feet, and of the left leg and thigh, and three weeks ago the abdomen began to enlarge, and the patient suffered from dyspnœa. The face was congested, but there was no pain about the heart, no palpitation, and no headache. The urine had a specific gravity of 1010, and contained a trace of albumen, some hyaline and granular casts, and leucocytes. Examination of the heart showed the apex-beat in the fifth intercostal space, four and one half inches to the left of the median line. The heart's action was irregular. A loud murmur was heard at the apex, but loudest over the mitral area; it was thought to be presystolic, and was not transmitted. There was, also, a loud systolic murmur at the base, loudest over the aortic area, and transmitted upward. A few sibilant and sonorous râles were present. The abdominal cavity contained fluid.

Autopsy.—The pericardial, pleural, and peritoneal cavities contained fluid. The left lobe of the liver was twice the size of the right, and the latter showed some cicatrices, was slightly hobnailed, and seemed to be cirrhotic. The kidneys showed many scars, probably from infarcts; the cortex was thickened, somewhat pale, and the markings were a little indistinct. There was stenosis of the mitral, aortic, and tricuspid valves. The tricuspid would not admit two fingers, was smooth, circular, and slightly funnel-shaped. The mitral admitted one finger, and was very similar in appearance to the tricuspid. The aortic valve would not admit one finger, was nearly circular in shape, and nodular. —*Med. Record*, Feb. 16, 1889.

Day (R. H.) on Idiopathic Acute Parotis; Sloughing of the Entire Gland; Recovery.—The patient was a mulatto woman of thirty-two, tall, thin, and narrow-chested. On Aug. 25, 1888, I found the left parotid very much swollen, very hard, and exquisitely painful; and the whole integument on the left side from the chin, back to the mastoid and down to the clavicle, diffusely inflamed, and so extremely sensitive that the softest touch produced the most excruciating pain. The pulse was small, frequent, and feeble, and accompanied with great systemic prostration. I advised the application of a hot flaxseed poultice over the gland and inflamed integument; chloral and morphine to ease pain and procure sleep; a liquid nutritious diet, and enemata as might be required to move the bowels, and five grains of quinine to be given three times a day.

On the 13th of September I found the patient much exhausted and reduced in flesh from constant excruciating pain and inability and disinclination to take food. The gland and integument were still inflamed and more distended and painful, with obscure fluctuation at two points: (*a*) at the upper edge of the gland, and (*b*) below the angle of the jaw. The doctor preceding me had supposed the case to be abscess in the mastoid cells, and had made a free cut down upon that process, but without finding any pus. I made a free incision at the two points designated; from the upper one about a tablespoonful of ill-looking thin pus escaped; from the lower opening only a little thin sanious fluid exuded.

These incisions into the parotid revealed the fact that the entire gland was in a sloughing process, that it was necrosed,

and undergoing disorganization. I could with gentle force pass a silver probe in different directions through the gland, causing not as much pain as was induced by touching the investing integument.

I insisted upon the regular and frequent administration of cow's milk, beef broth, Ducro's elixir and port wine, and small doses of quinine three times daily; fifteen grains of chloral with one quarter grain morphine were given as needed, both to ease pain and to procure sleep at night; I used a flaxseed and charcoal poultice applied warm and made fresh three times a day, and injected into the upper opening a weak solution of carbolized oil at each dressing.

Every alternate day I made a visit and removed with forceps and scissors such portions of the gland as I could draw through the opening, and that were manifestly dead.

On the 20th of September I lifted out through the upper opening the entire remnant of the gland in a coherent mass, which had been completely detached, leaving a deep sulcus, or hollow, extending down to the underlying blood-vessels. This cavity I had syringed out daily with a weak solution of carbolized oil, and applied over the integument a thick pad of carbolized absorbent cotton and oakum, so as to press the surfaces together, to exclude the ingress of air, and facilitate granulation. The dietetic treatment was continued, and the chloral and morphine were dispensed with. In addition, I now put my patient upon cod-liver oil, which I found of great benefit. The cavity gradually closed and healed over, the patient in the meantime improving in flesh and strength, and finally was restored to her customary health; leaving, however, a deep and marked depression in the site of the missing parotid.—*Med. News*, Feb. 23, 1889.

Claiborne (J. H.) on Papilloma in the Fauces.—A stoutly built German man of twenty-eight years of age presented himself at the Northwestern Dispensary, stating that his throat had been sore on the right side for some time. His impression was that something had become lodged in it while eating. Inspection revealed a whitish globular mass of about the size of one's ring finger lying between the anterior pillar of the fauces and the tonsil on the right side.

The mass was brought plainly into view by the gagging produced by the tongue-depressor. It was grayish in color, reminding me strongly in the color and in the character of its superficies of an etiolated or unripe strawberry. When it was picked up by the forceps it could be seen to be pear-shaped, being held to the upper tip of the right tonsil and to the mucous membrane of the adjoining sulcus and to that of the posterior aspect of the anterior pillar by a thin, grayish pedicle.

At my suggestion, Dr. R. C. Myles passed the wire loop of a nasal polypus snare around it. Gentle traction caused the rupture of the pedicle. The tumor fell into the mouth and was spit out on the floor.

In its gross appearance it was the type of a papillomatous tumor. By some accident the specimen became dried and flattened between two pieces of paper, and its histological characteristics became in consequence altered. I feel certain that a microscopic examination would have confirmed our diagnosis.

A mild antiseptic gargle was prescribed. The patient has not presented himself for treatment since.—*N. Y. Med. Jour.*, Feb. 16, 1889.

Iso-Nitroso-Antipyrin.—So much has been said lately about the toxic action of mixtures of antipyrin in sweet spirits of nitre, that two observers, Dr. H. C. Wood,[1] of Philadelphia, Pa., and Dr. G. Evans,[1] of Aberdeen, Miss., have made some experiments in this direction, and both claim that ordinary amounts of the mixture are perfectly harmless.

The latter observer gave doses of the mixture to animals and man, and found the only effect was that of the antipyrin remaining unchanged. The former experimenter used the isolated product, the iso-nitroso-antipyrin, and found it inert. He says that a very small and harmless amount of cyanogen develops if the mixture stands for some time, particularly on addition of an acid.

BOOK NOTICE.

Transactions of the Association of American Physicians. Vol. III.

This volume, the result of the third session of the association, in addition to the list of members and officers, contains twenty-four papers presented by the different members on subjects relating to general medicine. Some of these have already been noticed in the columns of this journal, and mention of individual papers is here impossible. They are better read and are well worth perusal in the original.

W. V.

[1] *Therapeutic Gazette*, Feb. 15, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRUGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LAPAROTOMY FOR INTESTINAL OBSTRUCTION.

At the Congress of American Physicians and Surgeons held at Washington during September, 1888, Dr. Reginald H. Fitz, of Boston, read a paper on "Intestinal Obstruction." He confined himself to the diagnosis and medical treatment of acute internal mechanical varieties of intestinal obstruction. The only causes recognized were strangulation from adhesions, vitelline remains, peritoneal slits, adhesions and rings, intussusception, knots and twists, abnormal contents, strictures and tumors. The evidence presented resulted from the analysis of 295 cases collected from medical literature since 1880. The most constant symptoms of obstruction proved to be pain, vomiting, tympany, and tumor. Stoppage of the bowel was not regarded as the most essential symptom, as frequent loose stools characterize intussusception, and may occur in other varieties of obstruction. Too much attention directed to this symptom, which is of frequent occurrence in peritonitis, often results in erroneous diagnosis, and leads to irrational and injurious treatment.

The physician is called upon to decide whether the given case be one of acute obstruction; then, where is its seat, and what is its cause; and finally, what is to be done. The diagnosis is to be made by the exclusion of peritonitis. The seat in the large or small intestine is to be determined by injection, under high pressure when necessary. The variety is, for most practical purposes, an intussusception or a twist of the large intestine, and strangulation or gall-stone of the small intestine. The differential diagnosis depends upon the relative frequency of these varieties, the age of the patient, the antecedent and immediate symptoms. The treatment consists in the attempt to relieve intussusception of the large intestine by forced injections under anæsthesia and with massage, and to treat obstructing gall-stones by opium, possibly with the aid of laxatives and electricity. All the other varieties of acute intestinal obstruction require surgical treatment. The latter is also necessary on or before the third day in cases of intussusception not yielding to forced injection, and in gall-stones when the symptoms are urgent.

Dr. N. Senn, of Milwaukee, said that the history of laparotomy for intestinal obstruction is only a repetition of the history of ovariotomy. The mortality of laparotomy for acute intestinal obstruction will be reduced to that of other intraperitoneal operations when surgeons recognize the importance of operating early, before the patient's strength has been exhausted by the disease, and before the parts involved in the operation have undergone irreparable textual changes. The mortality of abdominal section in the treatment of the different forms of intestinal obstruction, will always be great, because the conditions which have caused the obstruction are often an intrinsic source of danger. In

other cases, the removal of the obstruction necessitates an intestinal resection, which in itself is a vastly more serious operation than the removal of an ovarian tumor. Intestinal obstruction, irrespective of its cause, is always followed by a series of pathological changes which, independently of the partial or complete interruption of the passage of intestinal contents end in destroying life. The dilatation of the intestinal tube in the proximal side of the seat of the obstruction may give rise to such a degree of abdominal distension as to destroy life from suspension of important functions by mechanical pressure. In acute obstruction, violent peristalsis on the proximal side of occlusion causes an increased afflux of blood to the portion of the bowel which is the seat of exaggerated physiological action. This blood, after the cessation of peristaltic action, is the cause of intense capillary and venous engorgement. During the paretic stage, the blood-vessels in the intestinal wall have lost their support, hence transudation and exudation readily take place into the paravascular tissues, which, combined with the capillary stasis attending this stage of the inflammatory process, results in gangrene. The intestinal wall, in a state of inflammation, becomes permeable to pathological micro-organisms, which are always present in the intestinal canal, and which, after passing through the entire thickness of its walls, enter the peritoneal cavity and induce septic peritonitis—a frequent immediate cause of death. These facts are urgent reasons for adopting surgical measures in all cases of intestinal obstruction due to mechanical causes as soon as a diagnosis can be made. If this were done the greatest sources of danger attending and following laparotomy, shock, and septic peritonitis, if not entirely avoided, would at least be less likely to occur, and the tissues, the seat of operation, would be in a favorable condition for repair.

An abdominal section in the treatment of intestinal obstruction is always necessarily attended by some shock, and it is therefore of the utmost importance to perform the operation at a time when the organs of circulation and the nervous system are still in a condition to resist the immediate results of the operation. Death from septic causes can only be avoided by operating at a time when the intestinal canal at the seat of obstruction, and on its proximal side, is still in a condition capable of resisting infection, and of undergoing a satisfactory process of repair in case it becomes necessary to incise or resect during the operation. The statistics of operation will improve as soon as we are able by improved methods of diagnosis to make an early positive diagnosis, and adopt in the treatment positive surgical measures before recovery has been rendered improbable, if not impossible, by days and weeks of useless, and more than useless medication. True intestinal obstruction, whatever the cause may be, is as strictly a surgical affection as strangulated hernia, and remediable only by the same kind of surgical treatment. Physicians should recognize this fact, and call into counsel a surgeon as soon as a probable diagnosis of intestinal obstruction can be made. To let a patient die of the consequences of a removable cause of obstruction, without an operation, is a reflection upon modern surgery. Insufflation of hydrogen gas is a valuable means of diagnosis in locating the seat of obstruction before tympanitis has set in, and therefore best adopted at a time when most needed—during the early stage of intestinal obstruction. If the colon dilates uniformly from the sigmoid flexure to the cæcum, the obstruction must be sought for higher up in the intestinal canal. The passage of gas through the ileo-cæcal valve, rendered incompetent by the distension of the cæcum, is always heard most distinctly by applying the ear or stethoscope over the ileo-cæcal region. Not infrequently the sounds, are so loud and distinct that they can be heard at a distance of several feet. If the gas passes the ileo-cæcal valve under a pressure not in excess of that required to overcome it in a state of health, and if, after inflation, a thorough examination of the ileo-cæcal region by inspection, palpation, and percussion reveals nothing abnormal, the search for the obstruction is continued by inflating the small intestine slowly and making frequent examination of the abdomen to ascertain the height to which inflation has been made and to study the relative positions of the different abdominal organs. Inflation is also a useful diagnostic resource in locating the obstruction during laparotomy for intestinal obstruction. The intestine below the seat of obstruction is always empty, collapsed and anæmic as compared with the portion above the obstruction.

When the obstruction is located high up in the intestinal canal and the tympanites is extensive, the empty portion of the small intestine has by compression become displaced, and is often not readily found. In such cases the distension of the bowel from below will indicate to the surgeon at once the location, and length of the intestine below the seat of the obstruction. The manipulation of the healthy intact portion of the intestinal canal in search for the obstruction is a far less hazardous procedure than the handling of the distended portion above the obstruction, rendered paretic, exceedingly vascular, and much softened by obstruction. In cases in which we suspect the presence of a perforation, inflation with hydrogen gas will demonstrate not only its existence but also its location. Invagination is rare above the ileo-cæcal valve. Its location can be determined by inflation with hydrogen gas, and inflation resorted to early may prove the means of effecting the mechanical reduction. In ileo-cæcal and colonic invagination, slow and persistent distension of the colon with hydrogen gas, the patient being completely under the influence of chloroform, is the safest and most efficient means of effecting reduction, and should always be resorted to whenever these conditions are recognized or even suspected. (*Med. News*, Sept. 22, 1888.)

In a paper entitled "Enterostomy for Acute Intestinal Obstruction," published in the *Medical Record* (Sept. 1, 1888), the following conclusions are reached by Dr. B. Farquhar Curtis: 1. The mortality for laparotomy is 68.9 per cent. The mortality for enterostomy is 48.7 per cent. 2. In enterostomy 4.8 per cent. of the sixty-two cases died because the operation did not relieve the constriction; but even in laparotomy 5.8 per cent. of the 328 cases died from the same cause. 3. Enterostomy restores the natural passage for the fæces in 60 per cent. of the cases which recovered, while even laparotomy preserves it in only 79 per cent. of the recoveries. 4. Laparotomy is therefore so very little better than enterostomy, that in consideration of its greatly increased risk it is indicated only when the patient's condition is so good that he can bear the shock, and when the intestines are not so greatly distended as to offer a serious obstacle to a thorough exploration of the abdomen. 5. Under all other circumstances enterostomy should be performed, and, if necessary, this can be done without an anæsthetic. Laparotomy may be resorted to later to remove the cause of obstruction, and to close the artificial anus. 6. Whichever operation may be chosen, it is necessary to operate early, for every delay increases the risk of failure.

After giving the history of a case in which a portion of the ilium was exsected for gangrene following strangulated femoral hernia, Dr. John A. Wyeth, in a paper read before the Section in Surgery of the New York Academy of Medicine, March 14, 1887, says: 1. The treatment of strangulated hernia with gangrene of the intestine may be considered under three methods: 1. Establishing a permanent fæcal fistula at the seat of gangrene. 2. Immediate exsection of the gangrenous portion of the gut, by drawing the intestine out through the wound of operation, reunion of the ends by suture, and return of the loop. 3. Temporary fistula, followed after an interval of some days by laparotomy, excision and suture. To the first method may be consigned subjects so feeble that no operative procedure beyond making a fistula is justifiable. Whether exsection should be made at once, or postponed until after a free discharge through the fistula has been established, must be determined by the condition of the individual at the time of operation. If the patient is well nourished, and the anæsthetic well borne, it will be advisable to relieve the strangulation, and through the hernial opening draw out the gut until five or six inches of sound intestine above and below the gangrenous spot are in sight, remove the dead portion, and unite the ends at once. This is a much simpler operation than when an additional opening through the abdominal wall is required. In most cases, however, it will be found that the condition of the patient is not favorable for immediate exsection. Shock is almost always severe, and not infrequently fatal, when the constriction has been so severe or lasted long enough to produce gangrene. Finally, the subject of intestinal suture is one of such vast importance that too much stress cannot be laid upon the necessity for a thorough preparation for the operation. In the careful application of this procedure to penetrating wounds of the intestines, to exsection of gangrenous portions of the canal as the result of hernia, volvulus, intussusception, and in the removal of malignant neoplasm

and strictures, many lives may be saved which under the teaching of former years were left to die without surgical interference. The difficulties of the operation are great, and the time required in exsection dangerously long, unless the surgeon has had sufficient practice to enable him to work rapidly and safely.

GERTRUDE B. KELLY, M.D.

THERAPEUTICS.

Murrell (W.) on Tar and Apomorphine in the Treatment of Winter Cough.—The drug referred to is wood tar, *pix liquida* of the Pharmacopœia. The author makes it into a pill with lycopodium, or uses the *syrupus picis* either alone or combined with syrup of wild cherry.

When a more decidedly expectorant action is required, he adds a small dose of hydrochlorate of apomorphine, about one tenth of a grain. Everybody knows that apomorphine is a powerful emetic, especially when administered hypodermically, but it is not so generally known that it is one of our best expectorants. He uses a 2-per-cent. solution of the drug, and does not expect it to be freshly prepared, having found, from careful observation, the change of color which it undergoes on keeping in no way impairs its properties. From three to six minims may be given frequently without exciting nausea, and many people take ten without difficulty.

A winter-cough patient, who has been under the author's care eleven years, and has tried every remedy which has been suggested, says that nothing does him so much good as two teaspoonfuls of syrup of tar and ten minims of the apomorphine solution every three hours.—*Med. Register*, Feb. 23, 1889.

Hare (H. A.) on Strophanthus in the Treatment of Cardiac Disease in Children.—The author thinks strophanthus should not supplant digitalis, but be used where the latter fails. In connection with the treatment of heart disease in children, the author throws out the following useful cautions: "Very commonly the stunting of the child prompts the physician, after the heart is brought to a state of compensation, to the use of tonics, of large quantities of food, with the object of increasing the general development. This is, however, directly against the efforts of nature, for it should never be forgotten that the child is stunted because the heart can only supply a stunted body, and if the patient grows to the size of a normal child, the heart which can gather together enough strength for ordinary purposes finds itself with a body which is too big for it, and succumbs.

Again, in adults who have slight cardiac disease, it is often harmful to give tonics continually, since by so doing, the person becomes plethoric and the heart is strained. An interesting clinical fact is that "growing pains" are often all the history of rheumatism that we can grasp. I say "growing pains," because this is the name often given to the symptoms shown by the child, by the parents, but in reality they are evidences of a hidden rheumatism whose poison exerts its chief influence on the heart instead of the joints. Too frequently we are too much inclined to pass by such a history and to fail to ascribe any causative factor of such a nature to the case.—*University Med. Mag.*, March, 1889.

Clinical Notes on Sulphonal.—Dr. E. N. Carpenter gives[1] the synopsis of thirteen cases of insomnia in various forms of insanity treated by sulphonal. In eighty-five per cent. of the cases the result has been very satisfactory. He selected several of the most violent and destructive patients in his care, who were in the habit of receiving narcotics or hypnotics each night. Out of several hundred doses of the drug given, he has detected but very little effect on the cutaneous or renal secretions, no constipation, some nausea and vomiting, but this appeared in some cases of epilepsy exclusively.

In the same institution Dr. S. G. Burnett has experimented with the drug, and concludes[2] that it is a reliable hypnotic in the various psychoses void of depressive states—mania, the maniacal stage of paresis, delusional insanity, etc.; less favorable effects following its use in melancholia with pronounced depression. He says it is contra-indicated in arterio-sclerosis concomitant to a psychosis. He says it is seemingly accumulative, producing more profound effect after the third dose, six to twenty-four hours apart, and in a small number of cases disorders the digestive secretions, causing emesis, thirst, anorexia, etc.

[1] *Med. Record*, March 2, 1889.
[2] *N. Y. Med. Jour.*, March 2, 1889.

Testi on Thymol in the Treatment of Typhoid Fever.—At the Congress of Medicine, held in Rome, last October, Dr. Testi related his experience of thymol in more than 150 cases of typhoid fever. The results were most satisfactory. The temperature was reduced not, he maintained, by the withdrawal of heat from the body, as is the case with ordinary antipyretics, but by moderating its production. The antiseptic action of the drug was also marked; it diminished tympanites, checked diarrhœa, and notably lessened the putrefactive products usually found in the excreta. Dr. Testi also states that on microscopic examination he found a remarkable diminution in the number of mucous corpuscles, epithelial débris, and parasitic elements (especially granular) in the stools. The drug has also a marked effect in reducing the excretion of urea, and as it increases the blood-pressure it has no injurious influence on the action of the heart. The author strongly recommends thymol in typhoid fever as mitigating the severity of the disease and preventing complications. —*Br. Med. Jour.*, Feb. 23, 1889.

Durand (C. F.) on Collapse from Rectal Injection.—A boy, 13 years old, of a nervous and excitable disposition, and who suffers from incompetency of the mitral valves, was treated by me last August for pin-worms. I saw him about 8 P.M., and gave as an enema about one pint of a solution of carbolic acid (1 in 50). After the enema he complained of dizziness, and almost immediately went out to the closet.

About ten minutes afterward he was heard moaning outside, and when carried into his room presented all the appearances of collapse.

He was unconscious; pulse, 140; respiration very feeble and extremities cold. I administered stimulants and rubbed his arms and legs with whiskey, and applied warmth. Under treatment his condition gradually improved, but it was 3 A.M. before he showed any signs of returning consciousness. He was able to be up next morning, and on the following day was sufficiently recovered to go to school, but it was several days before he returned to his usual state of health.

Such serious effects from so simple a procedure as a rectal injection were due, in my opinion, to reflex action from the irritation of Meissner's plexus.—*Buffalo Med. and Surg. Jour.*, March, 1889.

Zambianchi and Mentalti, on Two Fatal Cases of Cocaine Poisoning.—A lady suffering from recurrent cancer of the breast, had $3\frac{7}{10}$ grains of cocaine injected hypodermically near the proposed site of operation. Immediately after she was seized with epileptiform convulsions, which lasted fifteen minutes. Artificial respiration was performed, and she rallied for a moment, but the convulsions came on again, and in five minutes more she died. The second case was that of a woman suffering from phthisis of one lung, to whom 22 grains of the hydrochlorate were given internally by mistake. Fifteen minutes afterwards she began to wander in mind, complaining that a morsel of food had stuck in her throat, and making fruitless efforts to vomit; at the same time she became so cold that she had to be wrapped in hot blankets. The delirium increased, her face was pale, the pupils dilated, the lips cyanotic, and the pulse imperceptible. Unconsciousness supervened, and in a short time she died. On autopsy there was found intense congestion of the brain and spinal cord, as well as of their membranes. The surface of the brain was covered with a thin layer of sanguinolent fluid, while the subarachnoid space was full of serum. Sections of the brain-substance in various directions showed everywhere innumerable minute bleeding points, the drops being confluent, so as to give the whole cut surface a reddish appearance. There were some recent hæmorrhagic infarcts in the healthy lung; the heart was firmly contracted, both ventricles containing a little blood; the spleen, liver, stomach, and small intestine were excessively congested; the kidneys and the bladder were normal. Precisely similar conditions were found in rabbits in which poisonous doses of hydrochlorate of cocaine were injected hypodermically.—*Lo Sperimentale.* Quoted in *Br. Med. Jour.*, Feb. 16, 1889.

Settier (A.) on Cocaine Poisoning by Vesical Injection.—A patient suffering from painful cystitis and chronic prostatitis had been in the habit of injecting 20 or 30 grammes of a 4-per-cent. solution of cocaine into his bladder daily, for seven months. When he came under the care of Dr. Settier, that gentleman determined to try the effect of injecting a solution of nitrate of silver into the bladder, previously made as far as possible insensitive by the injection of a 4-per-cent. solution of

cocaine. On the second day of this treatment Dr. Settier injected the cocaine, leaving it in for twenty minutes and then drawing it off. The caustic solution was then injected and drawn off, and lastly the bladder was washed out with warm water. As the pain caused by the nitrate of silver was severe and persistent, the patient himself injected cocaine into his bladder—an art in which long practice had made him proficient—and drew it off in from fifteen to twenty minutes. Soon after the last injection symptoms of a somewhat alarming kind showed themselves. The patient, who was naturally of a very taciturn disposition, suddenly began to talk with the greatest volubility. His sentences were unfinished, his speech indistinct, and his voice thick and quavering; he complained of giddiness and nausea; got up and sat down suddenly; and his gait was so unsteady that in walking he had to cling to the furniture. The tongue, mouth, and fauces were quite dry, the mucous membrane blanched, the body covered with cold sweat; the pulse was small and thready, beating 105 in the minute; he two or three times vomited glairy matter. Eight hours after the onset all these symptoms disappeared and the patient was quite well again. It should be mentioned that the course of recovery was twice interrupted by slight relapses, all the symptoms suddenly returning for a minute and a half.—*La Medicina Prat.*, Dec. 15, 1888. Quoted in *Br. Med. Jour.*, Feb. 16, 1889.

MEDICINE AND PATHOLOGY.

Freeman (L.) on the Disinfection of Surgical Instruments.—I have recently made a few investigations, assisted by Dr. J. C. Oliver, as to the bacteria existing on some instruments which had been for a long time in quite constant use. The observations were made at two different times, and the instruments were taken just as they were found in their cases.

On the first occasion I examined a pair of scissors, two knives, and a raspatorium.

In scraping the material to be tested from the instruments a scalpel was used which had previously been heated in a Bunsen burner and was reheated after each scraping. As soon as the scrapings were obtained they were stirred with the scalpel into melted, sterilized nutrient gelatine in test-tubes, and then poured out in thin layers on sterilized glass plates. The contained bacteria were allowed to develop into separate colonies, which were then picked out with a previously heated platinum wire and re-inoculated in gelatine tubes, on *agar-agar*, and on potatoes. In this manner pure cultures of each of the microörganisms present were obtained, and the microörganisms identified where possible.

On the scissors I found the lactic acid bacillus and the mould known as the *oidium lactis*.

One of the knives furnished the lactic acid bacillus, the *oidium lactis*, and two species of bacilli which I could not identify.

The raspatorium produced the *oidium lactis* and a bacillus not identified.

The remaining knife held the green-yellow bacillus, the *Bacillus Zopfii*, the liquefying water-bacillus, the red water-bacillus, the lactic acid bacillus, and the *oidium lactis*, besides several species of bacilli not thoroughly identified.

The lactic acid bacillus and the *oidium lactis* are so common, so widely distributed, that it was not at all surprising to find them on the instruments.

The green-yellow bacillus, the liquefying water-bacillus, and the red water-bacillus are all found in ordinary river water. They were probably deposited on the instruments during the process of washing.

The *Bacillus Zopfii* was originally found in the intestines of a fowl. How it got onto these instruments would be difficult to say.

Much to my surprise I found no pus-formers, in fact no micrococci at all; and, as far as the literature on the subject enabled me to judge, none of the bacilli present were at all pathogenic. This result emphasizes one fact very strongly,—how a surgeon, if he is lucky, may often operate with unsterilized instruments and yet have good results.

But my not finding pus-formers proves absolutely nothing. The condition required for existence by these micrococci are similar to those required by most other bacteria, and the moist material in the seams and screw-heads of instruments, not to speak of dried particles of blood and

pus, offer these conditions in a marked degree. By direct experiment it has been shown that the *Staphylococcus pyogenes aureus* when dried will retain its vitality for many days. So the fact that other microorganisms were present in such numbers goes to show that if the instruments had been recently brought in contact with pus-containing pathogenic germs, I should have found those germs present in my investigations.

In my second set of observations I confined myself mainly to the search for pus-formers. Plates were poured from four pairs of bone forceps, a knife, and an instrument-case.

On these instruments I found the *oidium lactis* and lactic acid bacillus as before. The leather instrument-case was especially rich in sarcinæ, principally the yellow sarcina. It contained also a great number of other bacteria. Most of the microörganisms found were bacilli—large numbers of them,—the majority of which I did not stop to identify further than to ascertain that they were probably non-pathogenic. There was only a single micrococcus present—a diplococcus.

The sarcinæ are common and harmless bacteria, and their presence on the instrument-case was to be expected as a matter of course.

As in my previous work, I was surprised to find no pus-formers. Either the instruments had not been recently contaminated or the micrococci had been killed by too prolonged desiccation. The result gives, however, only a false sense of security. The instruments contained every species of microbes, and the pus-formers could just as well have been present as not, and might have been present on the very next instrument examined.

Recognizing, as we must, that instruments may harbor the germs of suppuration, to say nothing of other pathogenic microörganisms, although they do not by any means always do so, our first duty is to disinfect our instruments.

Ziegenspeck recommends heating instruments in the flame of a Bunsen burner. This is not practicable in the majority of cases, as only metal articles can be so treated, and the edges of these are soon spoiled and the instruments ruined.

Dry, hot air will not answer the purpose. It requires a very high temperature to destroy bacteria with hot air. Koch showed that it took three hours to kill the spores of the *bacillus anthracis*. And it is neither convenient nor practical to use dry heat in all cases and for all instruments.

A 1 : 1000 solution of corrosive sublimate, or a five per cent. solution of carbolic acid, are the agents usually employed by our surgeons in the sterilization of their instruments; but these solutions are inadequate—they are not to be depended upon.

Martens has shown that cultures of the yellow pus-formers when suspended in 1 : 1000 bichloride are not destroyed in less than an hour.

As as experiment, I took a little of a pure culture of the yellow pus-former on the end of a platinum wire and allowed it to become dry, the condition in which germs usually exist upon instruments. I then placed the wire for five minutes in 1 : 1000 bichloride, moving it about in the fluid from time to time. Then I washed off the antiseptic in water filtered through a Pasteur filter, and drew the wire twice across some *agar-agar* in a test-tube. In a few days a luxuriant growth of the staphylococcus appeared along the entire lengths of both tracts of the inoculating-wire, showing that a vast number of micrococci had been left completely uninjured by the corrosive sublimate.

Thread, which may contain cocci within its meshes, is often merely doused in bichloride and used at once.

When corrosive sublimate is brought into contact with fluid containing blood or pus, the albumen is at once precipitated as an albuminate of mercury, so small a quantity as 1 ccm. of serum being sufficient to unite with all the mercury in 5 ccm. of corrosive sublimate. Behring estimates that bichloride of mercury acts with forty times less power on bacteria suspended in blood-serum than when suspended in gelatine, bouillon, etc.; and when the bacteria are mixed with pus, just the condition in which we usually find them, they are still more difficult to destroy.

In spite of all that has been said, there are plenty of surgeons who regard corrosive sublimate as our best disinfectant. Wittendorf, for example, makes this statement in a recent article on antisepsis.

Corrosive sublimate corrodes instruments quite extensively. On this account more than any other carbolic acid has largely taken its place. A five per cent.

solution of carbolic acid is certainly in many respects far superior to 1 : 1000 sublimate. Martens found that the pus-formers were killed at once when suspended in such a solution; even a three per cent. solution destroys them in one fourth of a minute, and a one per cent. in one to three minutes. There are two points in this connection, however, that require consideration. In the first place, pure cultures of the pus-former were merely *suspended* in the solution, so that the fluid could reach them easily on all sides. In practice the conditions are quite different, and much less favorable. On instruments the micrococci are perhaps intimately mixed with blood or pus or both, and the mixture more or less dried into the crevices and angles. It is difficult for the sterilizing fluid to directly reach them. How can we hope to effectually sterilize, for instance, a hypodermic syringe in a reasonable length of time, after its barrel has become contaminated with infective pus? The leather washers and angles of the syringe offer too many points of concealment.

Being unable to find any statistics relative to the action of a five per cent. carbolic acid solution on the pus-formers when they were mixed with blood and dried into the irregularities of instruments, I recently made a few experiments in that direction.

Taking some knives with corrugated handles, I rubbed a little of a culture of the yellow pus-former into the corrugations and into the angles between the handles and the blades. Blood was smeared over the infected places and allowed to dry. The knives were then placed in a five per cent. solution of carbolic acid and allowed to remain, one for five minutes and one for half an hour, and finally removed and washed in filtered water. The now fairly-well moistened blood was scraped off and inoculated in tubes of liquefied gelatine, from which plates were poured at once. On gelatine plates each individual bacterium develops into a separate colony. Now on all the plates poured from these instruments I found not only one or two colonies, nor one or two dozen, but hundreds of little growing heaps of pus-formers, showing that the carbolic acid had had very little, if any, effect on the germs protected by the coagulated blood.

I then prepared another knife in the same manner as the other two, and left it in the carbolic acid solution for one hour. The result was the same—the pus-formers were not destroyed.

I then made an experiment to see if Martens' statement regarding the instantaneous death of the pus-formers when suspended in five per cent. carbolic acid would hold good when the micrococci were dried on the end of a platinum wire. I immersed a wire infected in this manner momentarily in the carbolic solution, inoculated some *agar-agar*, and in a few days obtained a luxuriant growth. I then placed another wire in the antiseptic fluid for the space of five minutes. The bacteria were apparently all soaked off the wire, so that the extremity looked perfectly clean. I thought that in this instance, at least, every microörganism must surely have been destroyed. Inoculation on *agar-agar*, however, was followed in due course by a growth at one point. Some of the germs were evidently uninjured.

The second point to be considered regarding the disinfecting powers of the eight per cent. solution of carbolic acid, is that the pus-formers are not the only pathogenic germs with which we have to deal, although certainly the most common ones. We should possess a method of sterilization which will destroy every pathogenic germ with which we are acquainted, and within a reasonable length of time. The spores of the anthrax bacillus are the most resisting forms we know of, hence we should be able to destroy these spores before we are sure that we can fulfil all the conditions of asepsis. The five per cent. carbolic-acid solution here falls wide of the mark; it will not destroy anthrax spores inside of several days, as Koch has shown.

In consideration of what has been said, it is evidently unwise to pin our faith to either carbolic acid or corrosive sublimate, especially as we have another agent which costs practically nothing, is easy of application and always obtainable, and which is absolutely certain in its effects when properly used. This agent is common boiling water, or its equivalent, steam, at 100° C.

Where it is practicable to employ streaming steam, it is perhaps the more reliable and certainly the more convenient of the two, as the instruments can be more easily handled and they can be sterilized without tumbling against each other to the detriment of their cutting edges. Steam should, in general, be used in hospitals, and boiling water in private practice, where

it is not always easy to obtain a steam sterilizing apparatus.

Five minutes of continuous boiling is sufficient to kill the most refractive pathogenic organisms, no matter how they may be mixed with pus or blood, or how effectually they may be stuck away in obscure cracks or inequalities. This has been conclusively proved by Davidsohn in an elaborate series of experiments made in Koch's laboratory. Soyka states that water conducts heat twenty-seven times as rapidly as air, and in addition to this the moisture swells the cell-membrane and makes the organisms much more accessible to a given temperature than when in a dry state.

One or two precautions are, however, absolutely necessary if we would be certain of our results. The first of these is, that hollow instruments, like a syringe, should be completely filled with the boiling water. The second is, that the vessel should be a covered one, with only a small outlet for the escaping steam. This latter point is really the nucleus of the whole process.

If the vessel be nearly closed a temperature of 100° is maintained throughout including the steam above the water.

It must be understood that all kinds of bacteria are not destroyed by five minutes' boiling. There are some harmless forms which may be boiled for hours without injury. It is the pathogenic micro-organisms that are invariably killed by the process. It requires twenty or thirty minutes, for instance, to completely sterilize pus; but one may be positively certain that all the pathogenic bacteria are dead after they have been boiled continually for five minutes in a covered vessel.

Kümmel was perhaps the first to use steam in the disinfection of instruments, and steam is the best agent which we possess: but we must bear in mind two points: (1) Streaming steam acts more rapidly than steam in the quiescent state; (2) steam at 100° C. is a much better disinfectant than super-heated steam. Saturated steam is what is required, and the higher we raise the temperature the dryer becomes the steam. Air or super-heated steam must be raised to a temperature of 140° to 150° before it becomes as effective a sterilizing agent as ordinary steam at 100°. These facts have been recently brought forward by Esmarch. Hence, all disinfecting apparatus depending upon over-heated steam should be discarded. Sternberg, Soyka, Esmarch, Davidsohn, and numerous other reliable investigators all agree that a moist heat of 100° C. for five minutes is sufficient to kill with certainty *all* pathogenic bacteria and their spores.

It is a good rule to boil instruments just after and just before every operation. As soon as the operation is finished, each article should be carefully brushed in water, paying particular attention to cracks, screw-heads, etc., boiled, and then wiped dry with a sterilized towel. During an operation the instruments may be used directly from the sterilizer, or from a two and one half or three per cent. solution of carbolic acid.

Too little attention is generally given to instrument-cases. They are liable to become infected with pathogenic germs and re-infect the instruments which they contain. Instruments should be kept in trays on sterilized towels, or held in metal slots in boxes, so that the receptacles can be easily cleaned. At least, clean sheets of paper or napkins should frequently be laid in the instrument-cases.

A point of the utmost importance is that instruments should have smooth and continuous surfaces; there should be no cracks or screw-heads where it is possible to avoid them.

Among a surgeon's instruments his hands occupy a front rank. They are employed in every operation, and are among the objects most difficult for him to disinfect. Heat is here out of the question. Soap and water and various chemicals must be depended upon. Fürbinger, who has done much work in this line, says that thorough washing with soap and water is much more effective than short contact with any disinfectant solution.

The spaces beneath the nails offer most excellent hiding-places for all sorts of bacteria, and it is difficult to dislodge them from these strongholds. Dirt and moisture are always present, and the temperature remains fairly constant at 28° C.

Wittman examined scrapings from beneath the nails of twenty-five individuals and found seventy-eight kinds of bacteria, the majority of them being micrococci. Fürbinger often found the yellow pus-former beneath finger-nails, even when the hand had not been brought in contact with pus for days.

One of our surgeons very obligingly permitted me to examine the scrapings from

beneath his finger-nails, both before washing his hands and after he had cleaned them in the manner usually employed in preparing for an operation. The scrapings were removed with a sterilized knife and transferred to nutrient gelatine, from which plates were poured. Myriads of colonies grew upon each plate; and, strange to say, more bacteria were found after washing the hands than were found before that operation. This was probably because the water served to moisten the material beneath the nails and made it easier to remove by scraping. The vast majority of the colonies were micrococci.

These finger-nail plates were made merely for the purpose of demonstrating what a mass of micro-organisms occur beneath the nails under ordinary circumstances, and how difficult they are to dispose of by the usual methods of cleansing and disinfecting.

Upon the thorough disinfection of our fingers depends so much that every physician should be familiar with the very best process for accomplishing this end. Fürbinger has furnished us with perhaps the most reliable and convenient method. It is as follows:

1. Clean the nails well with a knife.

2. Brush the hands for one minute with warm soap and water, giving special care to the nails.

3. Wash and soak the hands for one minute in alcohol over eighty per cent., to remove fatty matters and assist disinfection.

4. Then plunge them immediately into a three per cent. solution of carbolic acid, washing and rubbing the hands carefully for a minute, not forgetting the nails.

When this process has been carefully gone through with, the surgeon can be reasonably certain that his hands are aseptic. His difficult duty is then to keep them so; in other words, to avoid touching all unsterilized objects.

To recapitulate:

1. Microörganisms of all kinds swarm about us; some are pathogenic, the majority harmless, so that a wound may or may not become infected, as chance directs.

2. Not enough attention is paid by most surgeons to the disinfection of their instruments. An examination of a series of instruments revealed a large number of various kinds of bacteria. No pus-formers were found; but this must be regarded as accidental, as the conditions were favorable for their existence.

3. The disinfecting agents now in use—carbolic acid and corrosive sublimate—are not to be depended upon, as shown by the experiments of others and by my own observations.

4. The best way to disinfect instruments is to expose them for five minutes to streaming steam at 100° C., or boil them for the same length of time in a closed vessel, both before and after an operation.

5. As far as possible, only smooth, seamless instruments should be used.

6. Instrument-cases should be looked after as presenting a source of infection.

7. The hands should be carefully cleaned with soap and water, soaked in alcohol, and then washed in an antiseptic solution, each step of the process to occupy one minute. —*The Cincinnati Lancet-Clinic*, March 4, 1889.

Brunner on the Diagnosis of Motor Insufficiency of the Stomach.—The author in this paper questions the reliability of the salol test given by Ewald and Sievers as a means of testing the motor functions of the stomach, and as the results of his experiments upon sixty healthy individuals concludes: That the condition of the stomach at the time of the experiment (as regards the amount of its contents) has but little influence on the time of the appearance of the reaction in the stomach. That under like circumstances, on different days the time of the appearance of the reaction in the urine is subject to great variability. To-day it may be forty, to-morrow seventy minutes, and that greater variations are not uncommon. That in many cases the reaction first appears at a time which far exceeds that given by Ewald as the limit for a healthy individual.

In one case, where dilatation of the stomach had been diagnosed by Ewald and Sievers, the author found that a test meal disappeared from the stomach sooner when faradization of the abdominal wall was practised, and that in spite of the increased motor activity under these circumstances, the salol reaction appeared at the same time, and even later than when faradization was not practised. The author further considers the oil test of Klempner, which was recently brought forward, with the same object in view, to be also unreliable. He considers the method used by Riegel to

be mostly depended upon. This consists in administering an accurately weighed test meal of mixed diet, and five hours afterwards emptying the stomach by means of a tube. From the amount and appearance of the stomach contents, conclusion as to the motor disturbances are with some experience easily arrived at. The method is not of mathematical exactitude, but allows of conclusions regarding the principal points, and every stomach which at the end of five hours is found empty, or containing only a slight amount, must be considered as normal. — *Deutsch med. Wochenschift*, Feb. 14, 1889.

W. V.

Ward (S. M.) on Two Cases of Colic in Adults, Produced by Intestinal Worms.—The first of these was in a woman, whose attack began with intense pain in the abdomen, no vomiting or diarrhœa; the pain was relieved by hypodermatic injections of morphia and atropia, and as the author found no contraindication to a vermicide he administered drachm doses of the fluid extract of spigelia and senna, and dislodged some twenty to thirty lumbricoid worms, with total and prompt relief. The second case was also a woman, who, four years previously, had had an attack of colic, which was relieved only after she had passed fifty to sixty worms. The present attack had come on suddenly, with pain in the abdomen, and later there had set in vomiting. Morphine gave some relief. An enema of soap-suds, castor oil, and turpentine brought away a few round worms. This was repeated in the morning again with similar results; but, the pain and vomiting continuing, the next morning an enema of a quart of strong infusion of senna leaves and spigelia root resulted in some relief and twenty worms, but the pain did not all disappear until forty more were passed the next day.—*Med. and Surg. Reporter*, April 21, 1888. W. V.

Annandale on Gastric Symptoms Relieved by Abdominal Section and Elevation of Depressed Ensiform and Costal Cartilages.—A young man eight years previously had received a severe blow upon the left side over the lower costal cartilages and sternum; dragging pain in the region of the stomach with vomiting had resulted, and continued, in spite of treatment, with more or less aggravation. Being unable to work, and the diagnosis from external examination not being satisfactory, an abdominal incision was made as if for gastrostomy, and the parts explored; no condition except a morbid depression of the lower costal and ensiform cartilages being found, these cartilages were divided and raised up. The result was complete relief to his old symptoms, and the patient, when seen two weeks ago (nearly six months after the operation) remained quite well.—*Lancet*, Feb. 16, 1889.

De Wees (W. B.) on Rupture of Transverse Ligament.—A healthy man of twenty-eight received a blow on the back of his neck, which felled him to the ground and produced unconsciousness for several hours, after which he, however, rapidly recovered, and in a few days was out again, following his usual vocation.

Several months later he was seized with epileptiform attacks, in which he would suddenly, without any premonition, fall forward on his face, unable to move, or even to breathe sometimes, for a few moments; then in an utterly helpless condition be compelled to lie for a short time ranging from two to five minutes, when full power of motion would return, and he would be able to raise himself and go about as usual. There was no regular periodicity about these attacks, nor was consciousness in any way impaired during the paroxysm. Despite all care, attention and treatment, the man continued worse until he was unable to leave the house. About eight months after the first attack, I was called to see the case. I found him resting upon a couch, in a pleasant and agreeable mood, and able, himself, to give me a minute account of the case. A careful inspection revealed a slight enlargement of the neck, posteriorly from just below the occiput to the third or fourth cervical vertebra. Upon pressure this region was painful. I laid my hands upon his head, and upon making pressure pain was elicited in this same region. I rotated the head slightly, moved it directly backward, and nothing but similar pain was manifested; but immediately upon bringing the head forward, so as to flex the neck, he became nearly pulseless and fainted, the limbs tremulous and agitated, the entire muscular system relaxing, and but for a prompt presence of mind on my part he would have fallen forward upon his face on the floor. He was immediately placed upon the floor, having all the appearance of a dead man. We laid him

upon his side, then upon his back, raised his head, but still he remained in the same nearly pulseless and syncopic condition. I now placed the patient flat upon his back while yet upon the floor, and with my hand under his neck I made pressure upward until a hard cushion was brought in answer to my call, which was then put under his neck, thus producing the primitive arrangement of the articulation between the atlas and axis, and in less than half a minute consciousness and all power of motion to the muscles was restored. I was satisfied that here was a case of a giving-way or relaxation of the *transverse ligament*, interposed between the ascending or odontoid process of the axis and the medulla oblongata, articulating the odontoid process with the anterior arch of the atlas, and thus preventing, in a normal state, injury to the medulla oblongata.

An air-bed was at once procured, the patient placed thereon, and confined absolutely upon his back; yet, whenever the small cushion was taken from under his neck, thus allowing it to sink down on a level with his shoulders on the bed, he could scarcely breathe; but as soon as I put my hand under his neck and lifted up the odontoid process, he was at once free from dyspnœa. I placed sand-bags one on each side of the head from the shoulders up, and one on each side of the body from the axillæ to below the hips, thus securing absolute rest; the bowels being moved by enemata when so necessary, and the urine drawn by catheter whenever required. No more attacks occurred from the hour of placing him in this position, except in two instances; he being of a rebellious nature, became determined to leave his bed about the middle of the second and fourth weeks, and no sooner was he out of bed and dropping his head simply to look around for his slippers, than he suddenly fell to the floor with a thud; after prompt attention and time, all passed off as before. But after the second time he resolved to keep his bed, and did so for sixteen weeks in all, without having another attack; after which time he left his bed and gradually exercised by riding in a carriage with a driver accompanying him, etc. Thus he was finally fully restored to health, and up to this date has enjoyed the best of health, though six years have now elapsed since his convalescence. — *Kansas City Med. Index*, Oct., 1888.

BOOK NOTICES.

Electricity in the Diseases of Women, with Special Reference to the Application of Strong Currents. By G. Betton Massey, M.D., etc., etc. Small 8vo, pp. 210. Price $1.50 net. F. A. Davis, 1889. Philadelphia and London.

In this work the author presents what he believes to be the first complete treatise on the electrical treatment of the diseases of women—and on the whole the work is very creditable. Gynecologists have generally shown by their writings that concerning electricity, which they have employed from time to time spasmodically in their practice, they know very little. This statement cannot apply to the author of the present treatise as he commenced as a neurologist and skilled electrician, and later studied and practised the application of electricity to the diseases of women.

His work, therefore, should infuse a more scientific spirit into gynecology, and should be perused and used as a guide by all in that speciality.

To say that the author is rather conservative in his ideas of the curative powers of electricity is only another way of saying that he understands his subject thoroughly. Enthusiasts in electro-therapeutics are almost without exception shallow pathologists and therapeutists, empirics of the most improved pattern. The mild enthusiasm of our author is unassailable because it is founded on science and reared with experience.

While not sharing the author's enthusiasm the reviewer appreciates his temperate spirit and, as compared with others, modest claims. We live in constant fear, however, lest some more aspiring claimant shift the seat of war from the pelvis to the chest, and announce the cure of phthisis by electro-puncture of the lung.

R. W. Amidon, M.D.

Hand-Book of Materia Medica, Pharmacy, and Therapeutics. Compiled for the use of students preparing for examination. By Cuthbert Bowen, M.D., B.A., etc. Small 8vo, pp. 366. Price $1.40 net. F. A. Davis, publisher, 1888. Philadelphia and London.

As stated in the preface all the drugs recognized by the "U. S. Pharmacopœia" and their officinal preparations are treated in detail. The form of a question-and-answer book has been adopted as admittedly the best means of conveying the greatest amount of knowledge in the fewest words.

Great care has been taken throughout the book to familiarize the student with the best methods of administering the various drugs he will be called upon to use, and with this object a large number of standard prescriptions have been introduced which he can either adopt or use as models on which to construct his own formulæ.

It is an admirable book of its kind and, though the author claims no originality, there is much skill displayed in the presentation of its subject-matter, which is arranged, after sixty pages of preliminary material, according to the physiological action of the remedies. The book is carefully indexed, well printed and bound, and should be in the hands of all students.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRUGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLES.

ARTHRECTOMY.

The operation now known as arthrectomy has much to recommend it to those who have felt that the routine excision of tubercular knee-joints was not in children necessary in the majority of cases.

Mr. Bilton Pollard [1] says: It is now recognized that it is the complete removal of the tubercular tissues which should be aimed at, and that the removal of bone, except in so far as it is diseased, or interferes with complete extirpation of other diseased tissues, or hinders efficient drainage of the joint, is unnecessary. The joints are freely opened, and all the diseased tissues removed. Many cases heal soundly under a single dressing, and without fever.

Dr. Fred Kammer,[2] translating from Dr. Mandry,[3] says: In the knee-joint in children typical resections were followed by serious defects in the growth and position of the joint, so that with this joint a typical resection is now almost universally acknowledged an unjustifiable operation. The operation consists of an incision over and through the patella or tendon of the quadriceps; extirpation of the entire capsule with forceps and scissors; thorough scraping in bone and soft parts of any tuberculous matter; no healthy cartilage or bone substance is removed; irrigation with sublimate solution; suture of the quadriceps or patella, with dropped catgut or sea-grass stitches; suture of the skin; Watson's splint; and, finally, plaster-of-Paris bandage. The results after 2½–3½ years showed in some cases almost normal mobility of the joint. The shortening is but slight, often not present at all, and sometimes there is actual elongation.

An editorial in the *Lancet*, November 24, 1888, sums up the matter as follows: 1. Every excision of a joint should be an arthrectomy—*i. e.*, a complete removal, as far as possible, of all diseased and injured tissues, with a minimum interference with the healthy parts. 2. By a successful arthrectomy healthy parts of a joint may be preserved, and function maintained. 3. Where rest and other palliative measures, carefully carried out, fail to secure a distinct improvement in a tubercular joint, early arthrectomy is advisable, as delay exposes the patient to the risk of general tubercular infection, to wider destruction, and to a more extensive operation at some future time.

H. H. Clutton [4] says: Excision was performed only in advanced cases of joint disease, but latterly it has been done by many surgeons much earlier, and with correspondingly greater success. In the former case, when the joint was disorganized, the operation was performed too late; and in the latter, when performed early in the course of the disease, a more severe operation was done than was neces-

[1] *Lancet*, June 16, 1888.
[2] *Annals of Surgery*, Dec., 1888.
[3] *Beitrage zur klinischen Chirurgie. Mittheilungen aus der chirurg. Klinik zu Tuebingen.* Bd. iii., Hft. 2.
[4] *Lancet*, April 21, 1888.

sary to procure a successful result. The operation of arthrectomy is performed early if possible, and aims at removing only the parts which are diseased, and leaving all the rest alone. I would urge that so soon as it is clearly demonstrated that the disease has not been arrested in its progress by an apparatus which gives absolute rest, the operation may be looked upon as one for consideration.

Mr. Edmund Owen[1] says that the hip-joint was not adapted for the performance of the operation as a primary undertaking in chronic disease, but as a measure supplementary to resection, arthrectomy offered much promise. By avoiding injury to the epiphyseal cartilages, the length of the limb might be preserved, and even a movable joint be retained, notwithstanding it had been kept at absolute rest for months. No manipulative attempts to secure motion ought, however, to be resorted to, and synostosis in a straight position more commonly resulted. In pulpy disease of the knee, or chronic suppuration of the articulation, the operation succeeded well if the disease was not too far advanced, but with albuminoid changes and general tuberculosis, it was contra-indicated. Arthrectomy possessed several advantages as compared with excision, especially in the fact that it involved the removal only of such tissue as was actually diseased, such removal being most frequently succeeded by a marked constitutional improvement.

Mr. G. A. Wright[2] believes that it is important to recognize that in certain cases, under certain restricted conditions, the operation yields better results than excision. He believes that the operation is chiefly, if not entirely, applicable to the knee-joint. His results in successful cases are better than those of excision, in that there is no shortening whatever, either immediate or as growth goes on, while the results in other respects are like those of excision, for a firm, stiff, straight limb is obtained. Mobility, though possible, is not to be counted upon. The operation is chiefly applicable to children.

Cases of both erasion and excision require long watching to prevent distortion, and there is little difference between the two in this respect.

Mr. Arthur E. J. Barker, in "Three Lectures on Tubercular Joint-Disease, and its Treatment by Operation,"[3] has discussed the whole subject very carefully. In discussing the relation between scrofula and tuberculosis, he says: It was not alone on the constant discovery of the bacillus and tubercle, be it remembered, that the theory of its causal relation to tuberculosis was based. Experimental research soon showed that no substance not containing these organisms was capable of producing in healthy animals the disease in question; and, on the other hand, that substances in which they were present, if inoculated with due precautions, invariably produced the disease in certain animals, not only locally, but, as a rule, also generally throughout the system. It is true that experiments at first appeared to point in the opposite direction; but a repetition of them, with proper precautions against error, left no doubt on the subject. And not only was the inoculation of fresh tubercle shown to produce in all cases a definite tuberculosis, but it was also demonstrated that the organisms in question, cultivated for many generations in various media, until all trace of contamination with matter from the original living tissue had been got rid of, were capable of producing this disease, when introduced into the animal body, with as great certainty as deep sleep is produced by the hypodermic injection of morphine. Again, the bacillus could be obtained in any quantity from tubercles produced in internal organs by inoculation of these cultivations in distant parts, and could be multiplied *ad infinitum* by cultivation, and propagated among some of the domestic animals with unerring certainty. Now it matters little whether the tissue from which the inoculations were made was taken from a scrofulous joint, or a typically tuberculous lung; the result was practically the same. And here we have, I think, the identity of the two diseases, tuberculosis and scrofula, proved to demonstration as clearly as any thing is capable of proof by experiment.

If one were asked to suggest the most potent factors in the predisposition of joints to tubercular disease, one would be inclined to say, in the first place, the inherent low vitality of the youngest tissues; and, in the second, high physiological activity—unless, indeed, we regard these

[1] *Medical Press*, Nov. 21, 1888.
[2] *Lancet*, Dec. 1, 1888.
[3] *Brit. Med. Jour.*, June 9, 16, 23, 1888.

two factors as one and the same thing. It is extremely difficult—nay, almost impossible—to accurately determine the relative frequency of tubercular disease starting in the synovial membrane and that starting in bone, and, after carefully examining numerous tables, compiled with a view to elucidate this point, I cannot say that they come even near definitively settling the matter. But one point, I think, may be accepted as almost certain, namely: that tubercular disease starts more frequently in the bone *alone* in childhood, and in the synovial structures alone in adult life.

As to operative measures, it is advised that they be resorted to as soon as caseation occurs, and before there is suppuration, as giving a wound that will heal quickly, and as being less likely to cause a general reinfection. It is advised that only the diseased tissues be removed, but that all that are diseased be thoroughly removed. Tables are given to show that the earlier the diseased tissues are removed the less the mortality, and the better the result. An early removal of the diseased tissues will almost always render a late excision unnecessary. The practice of excising in advanced disease cannot be too strongly deprecated. When tubercular disease is far advanced we shall find better ultimate results from the simple cleansing of sinuses and opening of abscesses than from excision, and better still from amputation.

JOHN RIDLON, M.D.

ACROMEGALIA.[1]

Hadden and Ballance report[2] a case (with photographs). The patient was a married woman, thirty-seven years of age. In striking contrast with her former condition, she is now a big-featured person, with a broad nose, prominent cheek bones, square, massive, and protruding lower jaw, and thick, everted lower lip. The condition of the nose is dependent on hypertrophy of the nasal cartilages and of the tissues over them, the nasal bones being unaffected. The enlargement of the upper and lower jaw bones is uniform, and seems to be due to simple hypertrophy. The skin of the face, though pale, presents no obvious alteration. Beneath the eyes there is distinct fulness, but no unusual pallor or translucency, and the circumscribed redness so commonly seen in myxœdema is absent. The cranium is natural. The neck is full and short, the subcutaneous tissue overabundant, and beneath the chin there is a pendulous, soft mass, probably fatty. No enlargement of the submaxillary glands can be detected. The thyroid gland is not to be felt; but it cannot be said with certainty that it is atrophied, since palpation is difficult in consequence of the fulness of the neck. There is slight fulness above the clavicles, and these bones are much curved, and distinctly larger and thicker than normal. The hands are gigantic, though in no way deformed. The hypertrophy appears to be general, but the subcutaneous fatty tissue is probably disproportionately thickened, especially along the inner border of the hand. The metacarpal and phalangeal bones are large, their outlines natural. The skin of the hands is moist, and in every way natural; the wrinkles are present on the backs of the fingers. The nails are large and broad, not otherwise affected. Broadly put, we may say that the increase in the circumference of the hand is 2½ inches. There is no enfeeblement of the grasp, and the woman says she can use the hands, even for threading a needle, as well as she ever did. The enlargement of the feet is in proportion even greater than that of the hands. She used previously to wear large 4 boots, afterwards large 6, and now large 8. At the root of the toes the right foot is 10½ inches in circumference, and across the centre of the sole 11½ inches. There is much subcutaneous fatty tissue along the outer border of the foot on the plantar surface, and below the internal malleolus, but very little over the dorsum. As in the hands, there is no deformity of the feet; they are simply gigantic, and nothing more. In marked contrast with the enlarged hands and feet, the forearms and legs exhibit no increase in size. The skin everywhere is soft, supple, moist, and in every respect natural. The hair on the scalp is soft and glossy, and has no tendency to become brittle or to fall out. The speech is not slow, but it is distinctly guttural. She articulates every word perfectly. The tongue is large, probably hypertrophied. The soft palate is normal. The heart and lungs are natural. There is no reason to believe that the thymus gland is enlarged, the percussion note over the upper part of the sternum being natural. The abdomen was not examined. No albumen has been found in the urine. Common sensation is

[1] See MEDICAL ANALECTIC, 1888, p. 232.
[2] Clin. Soc. Trans., vol. xxi.

intact, the muscular power is good, there is no wasting of the interossei or other muscles, and the intellectual processes are unimpaired. There is no tendency to free perspiration, no excessive thirst, no falling forward of the head on the sternum, no headache, no general pains, conditions observed by Marie in one or other of his cases.

Adler has reported[1] another case. The patient was a woman, thirty-four years of age, and a native of Germany. She was married in her twentieth year, and when she was twenty-three her wedding ring became so deeply imbedded in the tissues of her finger that it had to be removed with a saw. She suffered principally from pain in the back and weakness, and was also subject to frequent attacks of migraine. The pain in the back she attributed to a long ride, from the effects of which she never recuperated. She was unable to walk, and spent most of her time in a semi-recumbent position.

On looking at the woman, one was at once struck with the immense size of the head and the marked projection of the lower jaw. At the first glance, it looked like a case of myxœdema, or one in which there had been complete extirpation of the thyroid gland. The entire cranium was greatly enlarged, and the protuberance of the occiput was especially marked. The lower jaw was immense, and the tongue was greatly hypertrophied and flabby. There was no alteration in the teeth, except that those in the lower jaw were separated to some extent from each other; and the hair was abundant. All the lymphatics of the neck were greatly enlarged. On a superficial inspection there was an apparent lack of the thyroid gland, but a more careful examination, especially during the act of deglutition, showed that the left lobe and the isthmus could be distinctly felt, although the right lobe seemed to be wanting. No trace of the thymus gland could be detected. The clavicles were markedly enlarged, especially at their sternal extremities. The ribs were also greatly enlarged, and beginning kyphosis and a peculiar bulging shape of the chest, due to their hyperplasia, could be observed. There was comparatively little adipose tissue at any point. The bones of the arm and forearm all showed enlargement of the extremities, and there was reason to believe that slight lengthening of the shafts had also taken place. The hands were immensely enlarged, although there was no deformity of the nails, as has been noted in some of the other cases of acromegalia. The muscles everywhere were flabby and atrophied. The skin was markedly hypertrophied, but remained for the most part soft and pliant.

The same general condition of affairs was found in the pelvis and lower extremities. The feet were enlarged even more than the hands, being simply colossal in size, and there was also enormous hyperplasia of the epiphyseal region and the patellæ in the legs. It was noticed that there was marked hyperæsthesia in all the hypertrophied parts, even slight pressure causing the patient to wince. As regards the internal organs, a careful examination of the eyes with the ophthalmoscope revealed no organic disease. Repeated chemical and microscopical examinations of the urine showed no evidence of any kidney trouble, and the red and white corpuscles of the blood were both found to be normal in number and appearance, although to the eye the patient seemed anæmic. The heart and lungs and all the other organs, as far as could be ascertained, were entirely normal. The appetite was fairly good, but the bowels showed a tendency to obstinate constipation.

The electrical examination showed some departures from the normal. The resistance of the skin to the faradic current was enormous. Otherwise the cutaneous sensibility was not diminished. As regards the galvanic current, there was considerable diminution of the electrical excitability, which was most marked in the peronei of both lower extremities. Still, there was no evidence of any degeneration going on in the nerves, and the want of electric excitability could well be explained on other grounds. There was evidence of well-marked psychic degeneration in the patient. She was described as having been a bright and lively girl, but she was now very dull and apathetic.

The Berlin correspondent of the *Lancet* (Jan. 26, 1889) sends the following account of a remarkable case: "An extremely rare and interesting case of acromegalia, or abnormal development of the extremities, was exhibited by Professor Virchow in the Berlin Medical Society on the 16th inst., in the person of a Westphalian truckman of gigantic dimensions and herculean strength,

[1] *Med. News*, Oct. 27, 1888.

who can carry 8 cwt. on his back with ease. His head is the largest Virchow has ever seen, the circumference of his skull being 65.5 and its length 22.9 centimetres. His height is 183.8 centimetres. He has six children, and is in excellent health. In the course of the demonstration Virchow disputed the opinion of Professor Freund, of Strasburg, and other observers, that acromegalia is connected with puberty, and is inclined to the belief that it is hereditary."

JOHN RIDLON, M.D.

OCCASIONAL REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M.D.

Primary Union after Excision of Tubercular Hip-Joints.—At the meeting of the Royal Medical and Chirurgical Society papers were read on the above subject, by Mr. Barker and Bilton Pollard. Mr. Barker stated: 1. That scrofulous, or, in other words, tubercular joint-disease, was a local expression of infection of the tissues with the bacillus tuberculosis, and ran, as a rule, a course beginning in hyperplasia and ending in fatty degeneration. 2. That at a certain stage of the disease the complete removal of the infected tissues ought to be possible. 3. That if complete removal of the tubercular tissue from the hip be accomplished, the resulting wound ought to heal in many instances by first intention throughout, as in the case of the knee, and often even without any necessity for drainage. The author described his first case. The patient was a boy, aged five years, who had been under careful treatment for a year for hip-disease, which resulted in destruction of the head of the femur and the formation of an abscess of the usual kind. After operation on the lines indicated, primary union took place without drainage under one dressing, and the patient left the hospital on the fourteenth day, wearing a double Thomas' splint. The latter was removed in the eighth week after operation, and the child went to the seaside, when he began at once to run about, and had been quite well ever since.

Mr. Pollard drew attention to the fact that the wounds necessary for the extirpation of tubercle from joints would heal as rapidly and as permanently as other wounds of a similar size if certain essential conditions were secured: 1. The whole of the tubercular growth must be removed. 2. Perfect asepsis must be assured. 3. Bleeding must be checked and the wound made as dry as possible. 4. Oozing must be restrained by the even elastic support of a wool dressing and a moderately tight bandage. 5. Absolute rest of the part must be maintained during the process of healing. The hip-joint was selected for illustration of the views advanced, because the author thought that, of all excised joints, the hip had been found the slowest to heal. Four cases of advanced hip-joint disease with caseous abscesses were referred to. Three were operated upon by the anterior incision, and the fourth by a curved incision round the upper and posterior part of the trochanter. Drainage-tubes were not employed in any of the cases. The dressings were changed on the seventh day after the operations, and the wounds were found to have healed by first intention throughout. With the exception of one case in which the acetabulum was perforated, there had been no recurrence of the disease.—*Lancet*, Dec. 15, 1888.

Taylor (H. L.) on the Mechanical Treatment of Senile Coxitis.—By "senile coxitis" (malum coxæ senile) I understand a rheumatoid affection of the hip-joint occurring in old people, and characterized clinically by local pain, muscular spasm, wasting, stiffness, and disability, but never showing a tendency to suppurate. It may or may not be associated with similar troubles in other joints.

In several cases which had resisted previous treatment, and the patient seemed urgently to need help, we have tried the plan of applying counter-traction thoroughly, and then protecting the joint from all traumatism for a considerable period. The patient is put to bed with the long counter-traction hip splint and extra weight attached, the leg being supported in a sling. At the end of a month or six weeks we find the muscles about the hip-joint softer, and position and mobility improved, and allow the patient to go about on the jointed supporting splint ("Dows'"), which protects the hip-joint from pressure, but allows motion at the hip, knee, and ankle. The patient is thus enabled to enjoy the benefit of fresh air and moderate exercise, with a certain amount of healthy stimulation to the now quiescent joint, through the

protected and pressureless motion. If progress is not satisfactory, the traction in bed is repeated, and the patient again allowed to go about after a few weeks.—*N. Y. Med. Jour.*, Dec. 15, 1888.

Sayre (R. H.) on the Treatment of Rotary Lateral Curvature of the Spine.—The author says: The ribs and vertebræ are capable of being altered in their relative positions by muscular movements, and the disuse of the muscles is in a vast majority of cases the cause, so the proper use of them must be the cure, of the deformity. When the deformity is slight I rely upon gymnastic exercises alone for a cure, but if the case is more advanced, I find that the patient is not able to retain by voluntary effort so good a position of the body as can be obtained by partial self-suspension by means of a pulley and head swing. I therefore in these cases apply to the patient thus suspended a plaster-of-Paris jacket, which is cut down in front, supplied with lacings, and then worn in the daytime, being applied in the morning while the patient is partially self-suspended, and removed at night before sleeping. The patient exercises in the morning before the corset is applied and at night after it is removed.

The author then gives a number of very useful exercises, and illustrates them by numerous drawings.—*N. Y. Med. Jour.*, Nov. 17, 1888.

Willard (De F.) on Osteotomy for Anterior Curvatures of the Leg.—After carefully considering the various rachitic deformities and their treatment in detail, the author draws the following conclusions:

1. Anterior tibial curves during the soft and springy stages may be corrected by manual rectification and the use of apparatus.

2. Braces are useless after hardening has occurred.

3. Manual fracture is the best and safest remedial operation in young children.

4. Instrumental fracture, or osteoclasis, is not as safe or effective as osteotomy.

5. Aseptic simple osteotomy, for all moderate degrees of curve, and cuneiform section for very severe grades, give almost uniformly good and speedy results, without suppuration. Subcutaneous section by the saw is also a reliable operation.

6. Plaster of Paris is the simplest and most effective material for securing accurate position and maintaining absolute fixation. By its use the delay and injury incident to suturing the ends of the bones is avoided.—*Med. and Surg. Reporter*, Jan. 19, 1889.

McKenzie (B. E.) on Rest in the Treatment of Joint Diseases.—The object of this paper is to show that rest, mechanical and physiological, is the most efficient factor in the treatment of diseased joints.

When a joint is diseased nature's first effort at rendering assistance is in the direction of securing immobilization, by thickening of the soft structures about the joint, and by the contraction of the muscles which control its movements.

Priority in the invention and use of the "perineal and side splint with counter-extension" for the treatment of hip disease, is conceded to Dr. Davis of New York. As this splint is designed to be a perineal crutch, thus removing the weight of the body from the joint, while yet it allows free motion of the articulation, it fulfils one indication for securing rest, while in the movement permitted it signally fails in fulfilling a more important one. Sayre and Taylor followed on the same lines with modifications, but did not immobilize the joint. The inventions of Bauer, Andrews, Washburn, Barwell have all depended upon the principle of securing rest by supporting the body and extending the limb, thus relieving the joint of pressure, but as more or less movement of the joint was permitted, and in some instances sought to be maintained, rest was by no means secured for the diseased structures.

Having immobilized the structures which control the joint, no half-way measures must be adopted. There is no doubt that a vacillating mode of treatment, leading to the frequent removal of the retentive apparatus, and the occasional resort to passive motion, can result only in disaster, unless the curative power of nature be sufficient to rectify all mistakes.

Thomas has laid down rules for determining when the retentive apparatus may be safely removed and motion permitted. My observation of cases has led me to believe that his dicta, in this, are sound and based upon right principles. He says that immobilization should be maintained till all symptoms of inflammation have subsided; and then, having set the joint free, active movement is to be permitted, while

the joint is kept under observation. If the arc of movement increases with use, and if the limb can be brought by voluntary effort to the position in which it had been held by the apparatus, or if the joint be anchylosed, and no motion takes place through use of the limb, then the joint may be said to be sound. But if, after attempting active movement for some time, the arc through which motion is permitted is lessened, or if there is a tendency to assume a fixed position of deformity, or if, on removing the apparatus, no motion be obtained, but use of the limb causes it to assume a less practicable form, then the joint is unsound, and the fixation apparatus should again be employed. The limb that has any unsound joint should first be placed in a position which would be most useful if anchylosis should result, and then immovably retained in this position till all evidence of unsoundness has disappeared. When once resolution has been obtained beyond the possibility of relapse, let the restraint be removed, and the limb will regain its utmost range of usefulness by use alone.—*Canadian Practitioner*, January 16, 1889.

Ridlon (J.) on Double Hip-Disease; a Report of Fourteen Consecutive Cases, with Conclusions.

The cases are reported in detail, and the following conclusions are drawn :

The disease seldom begins in both hip-joints at the same time; and the second joint may become diseased while the patient is resting in bed under treatment for the first joint. In other words, traumatism can be excluded from the elements of causation of the disease in the second joint in very many cases.

The joint that is first affected is often the last to recover. This would seem to be due to the fact that before both joints are involved, and after one has recovered, the patient is allowed to walk around, giving the one diseased hip both pressure and motion, thereby delaying the cure and favoring anchylosis with flexion and adduction.

The duration of the disease in the first hip is usually somewhat less than that of the average case of hip-disease, while the duration in the second hip is usually much less than that of the first. This, it seems to us, can only be accounted for by the fact that during the time that both hips are involved the patient is kept pretty rigidly in bed, thus removing the superincumbent weight, and by that much diminishing joint destruction.

It has been thought by some observers that a second focus of disease has some derivative effect upon the first, thus : if, in a patient suffering from hip-disease, we have Pott's disease develop, the hip will recover sooner than it could reasonably be expected to under ordinary circumstances. There does not, however, appear to be any valid evidence of this "derivative action," since where two similar joints are affected, as the hip-joints, the last affected is soonest well; and we are, therefore, inclined to attribute the beneficial effect which the second has upon the first solely to the increased amount of rest which is necessarily enforced.

Freedom from pain has been uniformly gained by rest in bed and the weight and pulley. This device alone, however, is not sufficient to prevent flexion, adduction, or spontaneous subluxation in connection with abscesses. The application of the double long-traction-splint is much more effective. It sooner relieves pain, it permits of less movement at the joints, and the consequent ultimate flexion and adduction; and it can be used when supplemented by crutches, as an aid to locomotion, long before the joints unassisted could sustain the superincumbent weight. It does not, however, prevent the patient from assuming the sitting posture in or out of bed, and consequently does not prevent a recovery with the legs flexed; neither does it prevent abduction and adduction and anchylosis in either position. This is probably owing to there being a greater degree of muscular spasm in one set of adductors than in the other; or because spasm remains in the adductors of one thigh for some time after it has subsided from the adductors of the other thigh, and since the legs are held parallel to each other, the pelvis tilts and one extremity is adducted and apparently shortened, and the other abducted and apparently lengthened; and this is exaggerated if the patient be allowed to walk about, for as the patient swings his legs forward between his crutches, the adductors come more strongly into play than the abductors, and a cure with more or less of the "scissor-legged" deformity results. If, however, the tendency to adduction be on but one side, and that the leg which is actually the longer; or if adduction is the result in

the longer leg and abduction in the shorter leg, this real deformity becomes a less apparent deformity, and is a thing to be desired. So when one joint recovers with some motion before the other, which gives promise of having no motion, it is desirable to continue for some time the use of the long traction-splint, without any high shoe on the well side, to induce, if possible, the position of abduction. It would also seem that the double long traction-splint gives less good results when used as an aid to locomotion than when used upon a patient confined to bed during the active stage of the disease.

The double hip-splint of Hugh Owen Thomas serves a better purpose. It prevents flexion, and adduction and abduction. If the patient recover with anchylosis in one or both joints it is without flexion, and without apparent lengthening or shortening. Obviously it does not affect the real shortening. It prevents the child from assuming the sitting posture, and thereby prevents the motion which is very trying to the surgeon and very harmful to the patient, and, as a result, the duration of disease is shortened, and the tendency to, and duration of, the suppurative process and all its risks are diminished. Then, again, it does not permit of any locomotion until the joints are sufficiently well to bear the superincumbent weight without pain, thus diminishing the tendency to relapse. It is a very convenient apparatus for the nurse, since in it the child can, without pain, be carried from bed to lounge, or to another room, or to a carriage for a turn in the open air. By its use it may reasonably be expected that almost every child will ultimately recover without any deformity other than shortening due to actual erosion, and that a very large number of joints will recover with more or less complete motion.

A patient may go on without treatment to a perfect cure, but the result usually is anchylosis, with more or less adduction of one or both legs. This, however, is not a bar to locomotion; neither, in females, is it a bar to impregnation and safe delivery.

The more absolutely quiet the patient be kept, and the longer the period of quiet, the shorter will be the duration of the disease and the better the ultimate result.

If the patient be kept in bed, and the joint even moderately at rest, abscesses less frequently form, and, if already formed, less frequently go on to aspiration, incision, or spontaneous opening than when he is allowed to walk about.

The dangers to the general health from confinement in bed, provided the patient be free from pain, may be disregarded, since all of these cases improved in health during the time of their confinement. We would not underrate the benefit derived from pure air and sunlight, and these can be obtained with perfect comfort and safety when Thomas' splint is used.

The danger to the life of the patient from so serious a disease as this would not seem to be great. Only one of these cases, so far as I can learn, has died (Case I.), and that from tubercular meningitis supervening at a time when the general health was good.—*Internat. Journ. of Surgery and Antiseptics*, October, 1888.

OCCASIONAL REPORT ON DERMATOLOGY.

BY CONDICT W. CUTLER, M.D.

Dell'Orto (Dr. John) on Local Melasma.—Melasma may be local and temporary or general and permanent. Many of the latter cases are congenital.

The local cases may be accidental, as in a case reported by Lerat, of a lady whose face became completely black during three consecutive pregnancies, looking like a beautiful statue of alabaster with a head of black marble. After confinement the natural color gradually returned through exosmosis and a profuse transpiration which stained the clothes of the woman. Dr. Bayer reports the case of a lady in whom a sudden fright, while suffering from amenorrhœa, caused general melasma. Rostan reports a case of an old lady whose skin became black in one night, on account of a sudden grief.

General congenital melasma means that white parents may procreate a negro child, due to influences of the imagination of the mother on the fœtus. During the days of Hippocrates a lady gave birth to a negro child from the simple fact of having looked at the picture of a negro at the moment of conception. Albrecht speaks of a lady who at the eighth month of pregnancy fell under the ruins of a burning house; one month afterward she was confined with a child as black as charcoal. Plutarch, in the third volume of his moral

works, speaks of a Grecian woman having given birth to a negro child, was accused of adultery, but after an investigation, was found innocent.—*New Orleans Medical and Surgical Journal*, Jan., 1889.

Parker (W. R.) on a Novel Hair Disease.—The disease has been under observation ten years, and makes its appearance every few months. It begins suddenly as a tingling spot on the chin, which is followed by the presence of a tubercle from which a number of diseased hairs can be extracted, affording immediate relief. These hairs are easily extracted without pain, and surrounded by a glutinous cylinder of root-sheath with or without a little pus outside of it. The ends are always split up into a brush of two to six segments, the unsplit part having one or two white joint-like spots at which they very easily break off.

It is not a parasitic sycosis, as the most careful search has failed to find the presence of the parasite, and has but very slight resemblance to the simple sycosis. The disease seems to the author to be a peculiar form of acne mentagra.—*British Medical Journal*, Dec. 15, 1888.

Taylor (R. W.) on Lichen Ruber.—Dr. Taylor says that only in the second stage of lichen ruber, when the papules are fully developed, numerous, and distinctly clustered in groups, should the disease be mistaken for lichen planus. In the third stage, as a result of the coalescence of the papules, there occurs chronic infiltrated, pigmented, and scaly patches. Particular attention is directed to the nails, which become rough, serrated, much thickened, and dull or dirty yellow in lichen planus, while in lichen ruber there are no changes in the nail.—*St. Louis Cour. Med.*, Dec., 1888.

Carpenter (Julia W.) on Faradic Current in Pruritus Senilis.—The treatment of pruritus senilis by the use of the faradic current has of late been attended with marked success. It is best used three times a week at first, then twice a week, and later on once a week for some time, even if all symptoms have disappeared so as to prevent any return of the trouble. Usually the pruritus vanishes after the first few applications, and is very much relieved from the first.—*Cincin. Medical Journal*, Jan. 15, 1889.

Unna on Syphilis and Eczema Seborrhoicum.—Unna, in an exhaustive paper, discusses (*British Journal of Dermatology*, Dec., 1888) the occasional complication of syphilis of the skin with his so-called eczema seborrhoicum. He concludes that the syphilitic exanthem is so complicated :

1. Wherever the separate spots of the exanthem are of various sizes, confluent and not sharply contoured.

2. Wherever the papules are somewhat wanting in the specific syphilitic color, and look rather of a fresh, yellowish-red.

3. Wherever perfectly smooth papules are completely absent, but where, on the contrary, the greater part of those present are covered with scales and fatty crusts.

4. Wherever the papules are found arranged in serpiginously progressive circles and rings.

5. Wherever the peculiar yellow of the seborrhoic process is present round about the papules, and especially in the centre of the serpiginous circles.

6. Wherever the exanthem is accompanied by eczematous appearances, oozing, heat, and tension.

7. Wherever it produces itching of greater or less intensity.

8. Wherever the syphilides occur on the confines between the forehead and hair, in the naso-labial furrow, on the sternum, between the shoulder-blades, or in the sacral region.

9. Wherever they are concentrated entirely, or, for the most part, in the hairy scalp, in the axillæ, on the mons, on the genitals, about the anus ; in short, on the hairy regions or places of contact.

10. Wherever the exanthem exhibits an unusual obstinacy to constitutional treatment, whilst it at once improves, or even heals entirely under an antiseborrhoic local treatment.

The practical deduction as to treatment from the foregoing is, that whenever the coexistence of a syphilide with a seborrhoic process, or wherever a purely seborrhoic eruption exists side by side with a syphilide, the treatment must consist from the very first in the local application of antiseborrhoic remedies, such as resorcin, sulphur, etc., in conjunction with the general internal administration of mercury or iodine.—*New Orleans Medical and Surgical Journal*, Jan., 1889.

Hydroxylamin in Skin Diseases.—Dr. Eichoff, of Elberfeld, has found an admirable substitute in the chloride of hy-

droxylamin for pyrogallic acid and chrysarobin. It occurs in colorless, hygroscopic crystals which are soluble in water, glycerine, and spirits. When introduced into the blood it forms methæmoglobin, the blood rapidily becoming a deep brown color, and in large doses it produces hæmaturia. It is a powerful poison to low organic forms, on account of its reducing properties, and hence is strongly recommended in dermatology. It should be used in the proportion of 1 to 1,000, and painted on the affected part with a brush. It yields good results in eczema, psoriasis, syphilis, and ringworm.—Ed. *Lancet*, Feb. 9, 1889.

Stern on the Treatment of Xanthoma.—In the *Berliner klinische Wochenschrift*, of December 10, 1888, Stern reports the removal of patches of xanthoma by means of an application of a solution of corrosive sublimate. The growths, were seated at the inner canthus of both eyes, extending slightly along the upper and lower lids. These plaques were painted with a ten per cent. solution of corrosive sublimate in collodion, necessary precautions being taken to prevent the solution getting in the eyes. The parts painted became grayish and in a few days blackish; in a short time this was cast off, leaving a slight, superficial ulcer which rapidly healed. The author states that the result was all that could be desired, without the slightest retraction of the lids.—*Edin. Medical Journal*, Dec., 1888.

Jamieson (W. A.) on Removal of Corns or Callosities from the Sole.—A ring of glycerine jelly is painted about the lesion and when dry a circular piece of salicylic acid plaster (salicylic acid 40, creasote 40) is cut to fit within the ring. The jelly is now painted over both the plaster and ring several times, and when almost dry a layer of cotton wool is placed over all. The whole dressing can be kept in place with one turn of, a bandage, and should be cleaned once a week or oftener if necessary.—*Edin. Medical Journal*, Dec., 1888.

Treatment of Leukoplakia Buccalis.—Syphilis markedly increases the tendency to the production of patches of leukoplakia, and smoking in developing them. Even if there is no history of syphilis, antisyphilitic treatment seems to be beneficial in removing these lesions.

The local treatment is, however, of the utmost importance. All local irritants, as bad teeth, uncleanliness, tobacco, high-seasoned food, etc., should be removed or prohibited. Unna considers that chrome solution is the most important external or local application. He has but little or no good result from the local use of nitrate of silver, iodoform, or corrosive sublimate. He does not believe that the disease ever runs into cancer or is at all cancerous in its nature, but may predispose toward it by producing constant irritation of the tongue.—*Edin. Medical Journal*, Dec., 1888.

Jackson (G. T.) on Eczema of the Eyelids.—The following formula is highly recommended (*Monatsheft f. prakt. Dermat.*, 1888., vii., 1057):

℞. Cold cream, . . . 3 ii ss.
Resorcin, . . . gr. iii.
M.

Apply three or four times a day, avoiding applications of water.

—*N. Y. Medical Journal*, March 3, 1889.

Hutchinson (J.) on Solid and Persisting Œdema of the Face.—This disease is more common in women than men and is due to repeated attacks of erysipelas. The relationship of this post-erysipelatoid œdema and elephantiasis is very close, but there is not the growth of connective tissue and papillary hypertrophy seen in elephantiasis, there is simply solid œdema. The more frequent the attacks of erysipelas, the greater the deformity and persistency of the œdema.

The treatment should be general tonics and careful avoidance of sudden changes of temperature.

Ichthyol taken internally may prevent the frequent attacks of erysipelas.—*Edin. Medical Journal*, Dec., 1888.

MISCELLANY.

Rode (E.) on Syphilitic Disease of the Cervix Uteri.—Dr. E. Rode, of Christiania, has observed three cases of ulcerating gummata of the vaginal portion of the cervix. They appeared from ten to twelve years after infection. In all these cases there was extensive œdema of the pelvic connective tissue. Diagnosis was based upon the distinct history of syphilis, which was readily obtained from the patient. There were, moreover, no symptoms of local cancer, tuberculosis, or simple erosion. The patients all recovered rapidly after the administration of iodide of

potassium. No local treatment beyond simple cleanliness was thought desirable.—*Br. Med. Jour.*, Feb. 16, 1889.

Hill (W.) on Diphtheria with Patches in the Perineal Region.—The outbreak was sporadic, and limited to a house which was in an insanitary condition; amongst other defects, the soil-pipe of the water-closet was untrapped. Of three persons using this closet, three caught diphtheria, and two of these were first attacked in the perineum. A boy, aged ten, was the first victim; he died of pharyngo-laryngeal diphtheria. His father, who frequently suffered from an eczematous patch over the coccyx, noticed that this area became very painful and inflamed; subsequently, putrid and foul-smelling pieces of skin and slough came away for two or three weeks on the poultices which were applied. The gluteal lymphatic glands enlarged, and formed two symmetrical boils on each side of the groove of the buttocks. The patient suffered great pain, especially in defæcation. He never had sore throat. About six weeks after the appearance of the boils, typical post-diphtheritic paralysis supervened. Faradization followed by a sea voyage completed the cure. The second case was that of the former patient's little girl, aged eight, who, when her father's sores had just healed, suffered from frequent and painful micturition. The vulva was found swollen and œdematous, and there were several small sores and patches on the labia. Diphtheritic membrane formed on the tonsils, and eventually spread to the lungs. The urine had to be drawn off with a catheter. Two hours before death, which took place on the eighth day, fæces escaped by the vagina, indicating that the disease caused perforation of the recto-vaginal wall. This case was probably unique in this respect.—*Br. Med. Jour.*, Feb. 23, 1889.

[Diphtheritic lesions in unusual locations are rare and should always be sought for to explain the otherwise mysterious appearance of paralysis and other sequelæ of the disease.—EDITOR.]

Peebles (T. C.) on Hæmatemesis to the Extent of over Two Gallons of Blood, with Recovery.—A stout man of sedentary habits, aged thirty-two, weighing about 190 pounds, while measuring lumber, was taken, October 20, 1888, with faintness followed by sick stomach, when a quart of bright red blood was vomited.

Seven more hemorrhages occurred at various intervals up to the time the patient was brought to me. The amount of blood lost was not less than ten pints, in spite of many remedies used, viz.: ergotine hypodermically, turpentine, bismuth, opium, ice internally and externally, etc. November 8th, when the patient was brought to me, he was under the influence of morphia, and lay on his back on a canvas cot. I never saw a living person so bloodless, even his tongue was almost colorless. On examination I found no tenderness or pain anywhere over the abdomen. The stomach was distended, liver dulness apparently diminished, flesh white, flabby, and soft. Pulse 92, and thread-like; anæmic murmur over heart; temperature, 98°. Next day, November 9th, pulse 100; temperature, 99⅕°; vomited sixteen ounces of bright arterial blood, the interval from last hemorrhage having been sixty-eight hours.

November 13th vomited fifteen ounces of blood—interval, ninety-three hours; 15th, four o'clock P.M., vomited one pint of dark coagulated blood; 19th, one pint coagulated blood; 22d, twelve ounces bright red blood; 28th, eight ounces. December 6th and 7th, had two hemorrhages, which together made less than a pint. Total amount of blood lost was over two gallons.

This case was diagnosed as cirrhosis of the liver, and the patient was sent home to die. My treatment consisted in trying to nourish the patient by the bowels, giving both concentrated meat extracts and brandy in that way. Internally, at first he took pyrogallic acid in two-grain doses, with crushed ice every second hour; digitalis and fluid hydrastis; later, tincture of nux vomica and muriated tincture of iron. Friction, with a liniment containing nitro-muriatic acid, was applied over the stomach for the purpose of contracting that organ. The patient lay on his back for nine weeks, and great care was observed in allowing a return to solid foods.

The patient now weighs 160 pounds, has a good appetite, is gaining strength, and is able to walk around the village.

For some weeks after the hemorrhages my patient could not distinguish the features of his friends at the distance of ten feet from his bed. The light was also distressing to him. Previous to his illness his sight was good.

I feel satisfied that the hemorrhage came

from an ulcer in the stomach, and that it was not a case of cirrhosis of the liver. The blood was arterial, and was only dark and coagulated when retained longer than usual in the stomach.

On one occasion only was any blood voided by the bowels. The actions from the bowels were bilious throughout his sickness. —*Maryland Med. Jour.*, Mar. 2, 1889.

Gluten Suppositories.—Drs. Dixon and Egbert, of the University of Pennsylvania, have examined the so-called "gluten suppositories" to ascertain the appropriateness of the name. They find the suppository averages 13.735 grains in weight, while the average amount of gluten present is a little over *one half* a grain (.573 gr.). The rest of the suppository consists of starch and cacao-butter, and the analysts, for this reason, question the claim of the remedy to its present name.—*University Med. Mag.*, March, 1889.

R. H. Chittenden, Ph.D. on Observations on the Digestive Ferments.—In a paper recently read at the New York Academy of Medicine on this subject, the author presented the results of his observations as found in the physiological laboratory, and as he remarks: "A somewhat continuous study of the digestive ferments, in their relation to normal digestive action, has led to an accumulation of data, most of which, to be sure, have come from bottle and test-tube study, but yet, I think, not to be ignored on that ground; nor, on the other hand, are to be accepted in their entirety, but to be looked upon as statements of facts so far as they go, and as suggestions to be tested clinically when of sufficient importance." The author believes that the amylolitic ferments are destroyed by free hydrochloric acid in the stomach, but calls attention to the fact that nearly all forms of albuminous matter prevent the destructive action of the acid, and that while the proteids of the food probably protect for a time the ptyalin of the saliva, or other amylolitic ferments introduced, by combining with the hydrochloric acid as it is secreted, in a very short time these must become saturated and free acid be present, and as soon as free hydrochloric acid is present, or even before, a rapid destruction of the amylolitic ferments must take place. This has been confirmed by Ewald and Boas by clinical experiments, and the results of these showed that the conversion of starch into sugar in the stomach, when starch paste, mixed with a definite amount of hydrochloric acid, was fed to patients, took place within the first five minutes, the amount of sugar found in the fluid ejected from the stomach being the same at the end of five minutes as at twenty minutes; further, the amount formed is quite small, implying that the ferment is quickly stopped in its action by the acid present.

He then gives the effects of many common therapeutic agents on the amylolitic ferments, for which the reader is referred to the original. The remarks on the substances retarding and destroying the proteolyctic action of pepsin are full of practical import. He calls attention to the fact that when iodides and bromides are taken into the stomach they are decomposed, with the formation of hydriodic and hydrobromic acids, respectively, by which the retarding action of these two salts on gastric digestion is produced. Hence, as a practical result, the bromides and iodides should be given one half to one hour before meals. Alcohol in small quantities retards at first digestion, but it is quickly absorbed, and its disappearance is followed by an active, strongly acid gastric juice, which continues generally long after the food is entirely digested. Free acids, either mineral or organic, even a few thousandths of a per cent, completely stop the proteolyctic action of trypsin, and the presence of pepsin aids in this destruction. Hence it is obvious that pancreatic extracts or ferments given by the mouth can be of no value whatever, unless they are given in capsules or some similar way that they may be protected from the action of the dilute acids of the stomach (keratin capsules fulfil this indication,—Ref.).

The author considers pepsin to be a more efficacious solvent of pseudo-membranes, as in diphtheria and croup, than trypsin; but this for the reason that the trypsin preparations are not equal to the pepsin preparations on the market, and he advises for these purposes a fluid preparation containing 0.3–0.4 actual hydrochloric acid, the addition of glycerine, the heating of the fluid to the temperature of the body, and frequent repetition of the application to the membrane. He closes the article with a table of the relative proteolyctic action of the different pepsin preparations, the pepsinum purum in lamellis being the most powerful.—*Medical News*, Feb. 16, 1889. W. V.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRUGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON DISEASES OF THE NERVOUS SYSTEM.

BY FREDERICK PETERSON, M.D.

The Suspension Treatment of Locomotor Ataxia.[1]—This method of treatment of posterior spinal sclerosis was first brought to the attention of the profession by Dr. Motchowkowsky, of Odessa, in 1883. During the past year, M. Raymond and Dr. Onanoff while travelling together in Russia saw some of the results which had been obtained by Dr. Motchowkowsky, and upon their return to Paris M. Raymond instituted some experiments in this direction in his own clinic, with the assistance of his *chef*, M. Gilles de la Tourette. The discoverer of the method had used it in twelve cases of locomotor ataxia with benefit, and in a number of cases of impotence had restored sexual powers in the same manner. The modus operandi is merely the suspension of the patient by means of Sayre's apparatus every other day, beginning with one-half a minute and gradually increasing to four minutes. Every fifteen to twenty seconds the arms are elevated in order to increase the traction upon the cord. Professor Charcot has treated eighteen cases in this way, involving four hundred suspension séances, and corroborates all that had been previously stated with regard to its efficiency. Fourteen of the cases were markedly benefited. Improvement began immediately. The ataxia was diminished, and after twenty to thirty suspensions Romberg's symptom disappeared in most of them. Micturition became more regular and easy. Incontinence diminished or entirely disappeared. The lightning pains became fewer or completely vanished. Sexual desire and erections succeeded to impotency. Numbness in the feet disappeared. In none of the patients were the patellar reflex and eye functions restored. MM. Charcot and Blocq have tried suspension in other cases than ataxia with good results. Extraordinary improvement took place in a girl with Friedreich's disease, and the sexual functions were restored in two neurasthenic and impotent patients. A case of disseminated sclerosis treated in this way became afflicted with a temporary spasmodic paraplegia after two suspensions.—*Med. Press and Circ.*, Feb. 6, 1889.

Putnam (F. W.) on Hiccough and its Treatment.—The author describes hiccough as a clonic spasm of the diaphragm occurring during quick inspiration with partial or complete closure of the glottis. The simplest and mildest form is the accidental hiccough of childhood, easily controlled by domestic remedies. Sometimes it is very persistent, as in the case of a St. Louis lady whose husband secured a divorce on the ground that she had continually hiccoughed for twenty years. A pinch of snuff is said to be a sure cure for simple hiccough. Other cures are forcible flexion of the head, drinking water, swallowing cracked ice, sudden diversion of the attention by an unexpected noise or loud command, and compression of the ribs and

[1] See MEDICAL ANALECTIC, 1889, p. 97.

diaphragm upwards and backwards. Spraying the pharynx with water, a cocaine solution, or wine of ipecac is useful in the more obstinate cases. The inhalation of chloroform is the best remedy for the singultus of peritonitis.

In a case of phthisical hiccough, where morphia, chloroform, atropia, strychnia, bromide of potash, and galvanization were tried in turn for ten or eleven days without success, complete cessation was produced by the administration of one drop of a one-per-cent solution of nitro-glycerine every two hours.

In another case, lasting twelve days, nothing was effectual until a thirty-grain dose of chloral was given, which produced six hours of sound sleep and stopped the singultus entirely.

The hypodermic injection of one-half grain doses of pilocarpin succeeded in curing a case of very obstinate singultus which had lasted three months, and quite exhausted the pharmacopœia.

Faradism has been recommended by Dr. Hutchinson of Providence. One pole being placed over the axillary plexus, the other is stroked up and down over the sides of the chest. The current should be strong enough to produce contraction of the intercostal muscles.

The production of emesis, the Pacquelin cautery to the cervical spine, the application of the wet pack, a blister over the superior laryngeal nerve, Hoffman's anodyne, —all are found available at times.—*The Med. Register*, Feb. 16, 1889.

Harrison (G. Cooper) on Atrophy of the Deltoid and its Cure by Passive Circumduction of the Limb.—The author finds the literature of this affection very meagre, the suggestion being generally that it may be a form of rheumatism, which in his opinion it is decidedly not. In studying into the matter he was struck by the peculiar course of the circumflex nerve, which is totally unlike that of any other muscular nerve in the body. His theory of the origin of these deltoid atrophies, then, is that the circumflex nerve, in passing through the quadrilateral space, is rendered liable to injury, and even to strangulation. Falls upon the shoulder, stretching the arm beyond its due limit, or long-continued pressure in certain positions appear to cause atrophy of the muscle, and the writer suggests that the atrophy is due to strangulation of the nerve in the quadrilateral space, varying in degree according to the mode of injury, sometimes causing irritation and consequent hyperæsthesia, and sometimes complete interruption of the nerve current and paralysis. He relates some eight cases in illustration of his theory and of his treatment by circumduction. His second case is particularly typical and is here given as an example:

"Case 2. My next case was a widow lady, who six months previously had been attempting to reach something from a high shelf, when her left arm fell powerless to her side. She suffered much pain, and had been treated medically for six months without benefit before I saw her. The deltoid was quite atrophied; all the other muscles of the arm compared favorably with those of the opposite limb. Circumduction caused considerable pain, and the movements of the humerus were very restricted, owing probably to the locking of the head in the joint by adhesions or want of elasticity in the teres major and minor; but I persevered with the treatment, and had the satisfaction of completely restoring the limb, the atrophied muscle gradually resuming its former size and vigor."—*The Lancet*, Feb. 16, 1889.

Suckling (C. W.) on Multiple Neuritis in Brass-workers.—The author has met with few cases of ataxia in brass-workers, in one of which the knee-jerks were lost, and the case resembled locomotor ataxia, except that there were no pupil changes. He considers the ataxia due to a peripheral neuritis, caused by copper poisoning. He relates the following two cases:

Case 1. The patient, a man, aged thirty-nine, has been a brass-worker for twenty years. He has been a steady man, and not addicted to drink. About Easter last he began to suffer from pains in his legs, and especially from aching pains in his calves. The pains in the lower extremities were later on followed by slighter pains in the fingers, and still later by weakness in the legs and hands, so that in a few weeks he was unable to walk. There is a well-marked green line on the teeth, the lower half of the body of each tooth being stained of a deep green color, the typical staining of brass-workers. He complains of his fingers feeling hot, and there is slight tactile anæsthesia in the hands and feet, thermal and painful sensations being normally perceived. There is marked loss of muscular sense in the legs. He suffers

from double wrist-drop and foot-drop. The grasp is very feeble, and the fingers slightly flexed at all joints, there being inability to straighten them, or to extend the wrists. The feet are dropped and flaccid; the knee-jerk is lost on both sides. The calf muscles are tender when grasped, but there is not the extreme tenderness so often met with in alcoholic paralysis. There is emaciation of the arms and legs, but no œdema or change in the nails. The bladder and rectum are unaffected, and there is no bed-sore. There have been no mental symptoms, no dyspepsia or morning sickness, and he has not had syphilis, rheumatism, or gout. He is not phthisical or diabetic, nor has he been much exposed to cold, nor worked in lead. He has considerably improved since his admission into the Queen's Hospital under the influence of iodide of potassium and massage. On admission, he was quite unable to stand, and now he can walk about the ward, though his gait is of the high-action type. The electrical reactions in this case were normal, except that the faradic irritability was a little diminished.

Case 2. W. G., a man, aged thirty-one, a brass-finisher, was admitted into the Birmingham Workhouse Infirmary in June last. On admission, it was found that his gait was ataxic, and that the knee-jerk was lost on both sides. The grasp was very feeble, and he could not fully extend the fingers. The feet were dropped. He complained of numbness in the fingers and toes, and there was some actual anæsthesia in the inner borders of the feet. He had a well-marked green line on the teeth, and had often suffered from attacks of profuse sweating. The pupils responded normally to light and accommodation. There was considerable emaciation of the thighs, legs, and forearms, but no qualitative electrical changes, except that faradic irritability was somewhat diminished. He had been ailing eighteen months before his admission, and had been unable to walk for twelve months. He has greatly improved under the use of massage and the administration of iodide of potassium internally, being now able to walk well without ataxia.

The author finds relief in these cases to follow administration of iodide of potassium.—*Brit. Med. Jour.*, Dec. 15, 1888.

Coombs (C. P.) on Raynaud's Disease.—Those who are consulted about particularly bad chilblains during the winter months will feel interested in watching such cases, as they may turn out to be symmetrical gangrene. It is twenty-eight years since Raynaud described this disease. As an instance, take the following: A girl of sixteen walks in melting snow, and a few days after suffers much pain in her feet. The toes are swollen, sometimes pale in color, sometimes dark red, sometimes dark purple. The pain varies, and is often so intense that the patient will not allow her feet to be touched. The next stage may be that of gangrene, which is usually dry and superficial. In Raynaud's disease we have the familiar morbid changes of chilblains, the ischæmia of parts inclined to die from cold, the cyanosis of the hot stage of chilblains, the intense pain common to both, and the death of the skin of the worse patches occurs in both cases. It is believed that this condition is due to neuritis in Raynaud's disease, with a consequent vascular disturbance. In chilblains there is probably vascular disturbance only.

The author also compares herpes to Raynaud's disease. The darkened patches of zona, the vesicles, the small sloughs, dry, black, some separating and leaving granulating surfaces, the great systematic disturbance, all resemble the similar changes of the second and third stages of Raynaud's disease.—*Med. Press and Circular*, Jan. 2, 1889.

Swanzy (H. R.) on Eye Symptoms in the Localization of Cerebral Disease.—Focal eye symptoms are divided naturally into those due to disturbances of the motor apparatus of the eyeball, including the intraocular muscles, and those dependent upon changes in the special visual apparatus.

There is no centre in the cortex of one hemisphere (like that of the face, arm, or leg), a lesion of which will produce ophthalmoplegia, partial or complete, of the opposite eye alone. The two eyes being associated in their movements, it is only these associated movements which are represented in the cortex. The commonest cortical lesion deranging these associated movements is that causing conjugate deviation of the eyes to one side. As Prevost has expressed it, the eyes look at the cerebral lesion in paralysis, and away from it in spasm. It is very apt to be an indirect symptom, especially in cerebral hemorrhage; and when the centre itself happens to be involved in the lesion, its function, being largely bilateral, is rapidly taken up

by the sound hemisphere. Hence it is generally a transitory symptom. A similar deviation may be produced by a lesion of the internal capsule or of the pons, where it involves the special nucleus for the associated movements of the third and sixth nerves, but in conjugate deviation of pontine origin the eyes turn away from the side of the lesion in paralysis and toward it in spasm. Thus this symptom may assist us then in differentiating a cortical or capsular from a pons lesion, and in deciding upon which side the lesion exists when other symptoms are not readily observed, as in coma.

Paralysis of the upward and downward motions of both eyes, sometimes with ptosis, while the lateral motions are unimpaired, may be the result of a focal lesion of the third nerve nuclei in the flow of the Sylvian aqueduct; and if attended by hemiplegia, the lesion involves the pyramidal tracts, probably at the level of the anterior quadrigeminal bodies, the posterior commissure, and the neighboring part of the optic thalamus.

Loss of power of convergence, accompanied sometimes by paralysis of accommodation, is a symptom, though occasionally an indirect one, of lesion of the posterior quadrigeminal bodies.

Deviation of one eye downwards and outwards, while its fellow is turned upwards and inwards, has only been seen with lesion of the middle cerebral peduncle.

Ptosis has a cortical centre, but its position is unknown. Monolateral ptosis, with no other focal symptom, occurs only in cortical lesions.

Lesions causing bilateral paralysis of branches of the third nerve, which are wont to be innervated together, are to be sought for in the quadrigeminal bodies.

When the third nerve is paralyzed by a lesion in the crus, it is usual for it to be involved as a whole; but sometimes the branch to the levator palpebræ may be paralyzed alone by a lesion in the cerebral peduncle.

Complete paralysis of the third nerve, without any other paralysis, is almost always basal.

Solitary paralysis of the fourth nerve is extremely rare, and usually basal when it occurs. Combined with paralysis of the third, it is evidence of a lesion in the cerebral peduncle, extending back to the valve of Vieussens.

Solitary paralysis of the sixth nerve is usually basal, or an indirect symptom of a distant lesion, as from pressure by an intracranial tumor.

Paralysis of the sixth and the facial, with hemiplegia of the opposite side of the body, indicates a lesion in the pons, on the side of the paralyzed nerves.

Lagophthalmos is absent, or very slight, in a lesion of the facial cortical centre, or of the internal capsule, but markedly present in lesion of the facial nerve itself or the portio dura in the pons.

The condition of the pupils is rarely of much value in regional diagnosis.

As to the localizing symptoms derivable from the visual apparatus, hemianopsia is one of the most common and valuable. It may be caused by a lesion in the cortex (the occipital lobe), or in the fibres anywhere between the cortex and the optic chiasm. The absolute optical centre is in the cuneus and superior occipital gyrus, while the color-sense is in the posterior part of the superior and inferior occipito-temporal convolutions. There are eight cases of hemiachromatopsia on record. Relative hemianopsia can only occur with lesions of the cortex. Pronounced distant symptoms, such as hemiplegia, hemianæsthesia, ptosis, etc., bespeak a lesion in the internal capsule, or somewhere in the radiations. In hemianopsia due to lesion of the optic tract, it is usually complete, and there is the hemiopic pupillary reaction (if the pupil contracts actively to light concentrated on the blind side of the field, the lesion cannot be in the tract; but if it does not react, the lesion must be in the tract).

Total blindness of both eyes, appearing as a focal symptom—apart from certain cases of double cortical hemianopsia, or of cortical hemianopsia, combined with a lesion of the opposite optic tract,—can only be due to a lesion involving the whole of the chiasma, or both optic tracts. Clinical evidence is opposed to the idea that lesions of the corpora quadrigemina produce blindness.

Mind-blindness, or loss of visual memory, is due to a lesion of the occipital lobes. Some authors state that hemianopsia is present in all cases of word-blindness.

Optic neuritis has practically no localizing value. It occurs in most cases of intra-cerebral tumor, irrespective of the seat of disease.—*The Lancet*, Nov. 17, 1888.

MEDICINE AND PATHOLOGY.

A Standard Page for Reprints.—Dr. Charles Everett Warren, in the *Boston Medical and Surgical Journal* March 7, 1889, makes the following valuable suggestion :

The writer has a room full of reprints, catalogues, bulletins, and the like, and has tried every way imaginable for preserving them in order. Such as match in size can be bound together, others varying in size are put into numbered boxes. Others lie around promiscuously until some one, tired of seeing and moving them about, puts them into the basket. Circulars are supposed to be folded to postal-card size, endorsed and filed in a card index, together with cards containing references to the reprints, etc., but with the best system it is difficult to arrange the mass of material in a satisfactory manner, so as to be easy of access ; and therefore much of it is lost.

The remedy for this existing evil is, uniformity in size of pages, a remedy easily applied, if those who issue the printed matter will co-operate in its application and those who receive the matter will demand this. I suggested some years ago that a uniform size of page be adopted by mutual consent as a standard. The most convenient size would be the 8vo. There is nothing that could not be well represented in one of these sizes. The value of a catalogue with standard pages would be one hundred per cent. greater than one a little off size, as the former could and would be preserved for future reference, while the latter would be thrown away, even if it contained valuable matter, as it would be a nuisance and a clutter-monger ; even if preserved it would be amongst such a heap of good, bad, and indifferent, and its position would be so uncertain, that few would waste the time and the patience to hunt it up, provided it was not forgotten. Out of sight, out of mind ; one might as well be without a thing altogether as to not know where it is, or be unable to find it. Important as this question of uniformity is in the mercantile world, it is of still more importance in the scientific world. Monographs, reprints, and the like, have a historic value aside from their present intrinsic worth, and any point in their make-up tending to further the possibility of their preservation in a form suitable for reference, is worthy of careful consideration and adoption.

Other points favoring preservation of printed matter are good paper, type, ink, and presswork ; and intelligible description free from bombastic or ambiguous terms. A few positive statements of facts are much better than a mass of superlatives which contradict facts on their face. Our language is in need of a new degree of comparison, for superlatives have done so much duty as positives that we have no means of expressing the highest degree. Illustrative cuts are of great value, but they should be drawn to scale, and every description of apparatus should bear the date and give its price.

Sheild on Ulceration of the Tongue and Mouth, Cured by Opium.—A carpenter, aged fifty-six, had suffered for three years from obstinate ulceration of the sides of the tongue and gums. The affection varied in severity from time to time, but was always a serious trouble, and sometimes prevented him from eating or speaking. No cause was attributed for the occurrence of this malady. He had been a temperate man, and had never suffered from syphilis, or been employed in glass-blowing, or was immoderately fond of pipe-smoking. He had, however, been living in a poor way, and his general health had deteriorated greatly. A variety of treatment had been adopted without relief. On examination, the man looked pain-racked, worn and haggard. There were marked fetor and salivation. The left side of the tongue was superficially ulcerated in several places, the ulcers being covered with debris of food and superficial slough. The right side of the tongue was less affected. The gums were ulcerated round the teeth, and the posterior molars were loose. The mucous membrane was healthy, excepting in the situation of the ulcers. The glands beneath the jaw were enlarged. The ulcers were acutely painful, and the man had to subsist upon fluid nutriment, which he swallowed with difficulty. For three weeks the tongue was treated without any benefit. The remedies employed were small doses of blue pill and colchicum, potassium iodide, and tonics ; locally, solutions of cocaine and antiseptic mouth washes. A solution of chromic acid seemed only to aggravate the malady. After three weeks the use of opium was commenced ; an opium pill of one grain

was administered thrice daily, and a simple carbolic mouth wash used locally. In three days the pain was much less, and the ulcers were decidedly more healthy in appearance. In three weeks the ulcers had entirely healed, the only sign to indicate their previous presence being the glazed appearance of the sides of the tongue and the loose teeth. The man, being able to eat and drink freely, had wonderfully improved in appearance. The use of opium in this case was suggested by a paper read by Mr. George Pollock and published in the *British Medical Journal* of April 26, 1884. There he narrated a case very similar to the above, though much more severe, where the effects of opium were most beneficial. His patient had undergone a variety of treatment, including the application of nitric acid, by an eminent authority. The action of opium was difficult to explain in such cases; its undoubted efficacy in painful and sloughing ulcers was perhaps hardly enough appreciated in the present day.—*Lancet*, March 2, 1889.

Drysdale (C. R.) on the Curability of Syphilis.—The statement made by Dr. Gowers (Lettsomian Lectures, *Journal*, February 16, 1889), that "syphilis is an incurable disease," is so categorical and so straightforward, that it marks an evident advance in the knowledge of that terribly common malady. My own experience makes me agree with this short statement of the actual behavior of syphilis, even under the most careful therapeutics by means of mercury and iodide of potassium. For some years I treated a number of cases of syphilis without mercury in the early periods, and was amazed to find that, in healthy young adults, the initial lesion and secondary rashes often rapidly disappear, and the patient got into good health, and continued well for an indefinite time. Gradually, however, I found that a certain number of such patients had tertiary or gummy disease, and, as Dr. Fournier, the greatest Parisian writer, vigorously alleged that the non-use of mercury in the early stages of syphilis was the main cause of such tertiary lesions, I gave all my patients at the Rescue Society's Hospital for many years small daily doses of mercury and chalk (as Mr. Hutchinson advises), or of the green iodide of mercury, for many months together. This treatment was also most successful; but I lost sight of my hospital patients, and don't know whether many of them developed gummata in after years or not. But, among private patients, I regret to say that, as far as I can see, even the most careful treatment by mercury will not enable us to say that the patient will have no such symptoms. Again, I agree with Dr. Gowers in his praises of iodide of potassium in gummata; I also doubt whether it is necessary in such cases to follow up the iodide with a mercurial course.

Finally, one word as to the prevention of syphilis. I once, in 1867, believed in the Parisian plan of the Bureau des Mœurs; but on visiting Paris, and studying the question as well as I could, I found that true syphilis was extremely common in Paris, and that indeed it had increased in frequency, just as the St. Lazare prison had been more and more employed to terrify the female population of Paris. Hence I concluded that the only law likely to prove efficacious would be one which should assist in the prosecution of all persons, male and female, who infected their neighbor, and I only wait until society has become tired of other plans in order to propose this. Dr. Gowers, at the end of his lectures, uses the term "chastity," and advises it as a preventive of syphilis. I presume, but I am not sure, that he exempts marriage when he talks of the perfect health of continent persons, for it is well known that married people live far longer and are more free from diseases than celibates, and early marriage is the best preventive of syphilis.—*Br. Med. Jour.*, Mar. 2, 1889.

Finlay on a Case of Tubercular Disease with Inversion of the Temperature Curve.—The patient was a child nine years of age, coming into the hospital in March, 1886. She was stated to have had good health up to six weeks before admission, when she began to suffer from general malaise, with headache and loss of appetite. A brother had quite recently recovered from an attack of enteric fever, and the patient herself had been treated for enteric fever at another institution. On admission her pulse was 80; temperature, 98.6° F.; respiration, 23; tongue dry, red, and coated with a thin brownish fur; lips dry, and coated with sordes. There was no eruption, and she had an occasional dry cough. The abdomen was distended and tympanitic, and the bowels confined. Some scattered

coarse râles were heard over both sides of the chest. After a few days in the hospital the bowels became loose, the stools being light in color and offensive. Towards the close of the case palpation of the abdomen gave the impression of some matting of the intestines, and a trace of albumen appeared in the urine. The temperature curve showed, with only two or three exceptions, low evening and high morning readings, the former ranging faom 96° to 98.4°, the latter from 99° to 103.4°. She died on the twenty-first day of her stay in the hospital. From the history and other points, the first impression was that the case was one of relapse of enteric fever, but after a few days the diagnosis of tuberculosis was made, chiefly on account of the peculiarity in temperature above referred to. This conclusion was borne out by the post-mortem examination, tubercles being found in the peritoneum, lungs, pleura, pericardium, spleen, and kidneys. There was also evidence in Peyer's patches of previous ulcers, which had healed; and this, together with the history of the case, made it appear probable that a mild attack of enteric fever had preceded the development of general tuberculosis. The difficulty in diagnosis in some cases between tuberculosis and enteric fever was referred to, and the opinion expressed that the inversion of the temperature curve was a point of great importance in differential diagnosis, especially where, as in the case related, it was so conspicuous and constant.—*Lancet*, March 2, 1889.

The Action of the Venom of Snakes.—A Russian savant, M. Feoktistoff, recently published[1] the results of his investigations into the effects of snake-bites on the animal economy. He made 295 different experiments with the virus of two varieties of vipers and that of the rattlesnake. In some instances the animal was bitten by the snake and in others the poison was inoculated. The physiological effect was identical in all the three, but the rattlesnake secretes ten times as much venom as the viper. The venom itself is a yellowish liquid of neutral reaction, yielding thirty per cent. of dry residue, which, when redissolved, proved to be less actively poisonous than the original solution. Prolonged boiling destroys the poisonous properties altogether. Bacteria and spermatozoa are not affected by the poison, but frogs, fish, and mammifera all succumbed with the same symptoms, viz., dyspnœa, asphyxia, and convulsions. The stools, urine, and nasal mucus contained blood, and paralysis of the muscular system supervened, followed by death due to pulmonary and cardiac paralysis. The paralytic symptoms in warm-blooded animals always began in the hinder extremities and rapidly spread. The pupils become dilated and the heart stops in diastole. Blood pressure is markedly diminished together with the temperature. The red blood corpuscles in the body do not appear to undergo any change in shape, but under the microscope the addition of a small quantity of the virus seems to cause their solution. The principal pathological lesion *post mortem* is extravasation of blood throughout all the organs. The venom contains no micro-organisms. No adequate means are yet known of checking this tendency to extravasation, and, except in mild cases, stimulants are worse than useless.

According to Dr. A. Müller[2] of Yackandaudah, Victoria: "By far the most difficult of explanation among the symptoms of snake-poisoning, and the most fruitful source of error in the interpretation of these symptoms, are the peculiar and characteristic blood changes accompanying snake-bite. The dark fluid condition of the blood, combined with the death and disintegration of so many blood corpuscles, was taken as *prima-facie* evidence of a wholesale blood-poisoning process, and all the other distressing symptoms merely as the result of it.

"To ascertain, in the first place, whether the snake-poison has any direct and immediate anti-plastic effect on the blood, I carefully dissected the poison glands from the head of a tiger-snake specially shot for that purpose. The glands were thoroughly crushed in a small mortar, with a few drops of water added, and all the liquid separated by pressure dropped into a test tube. I then procured a young fowl and opening one of its carotids, allowed the warm blood to flow on the poison until the tube was nearly filled. It was then immediately corked and immersed into water of blood heat, where I kept it for some ten minutes, all the time keeping the blood in motion by shaking the tube. Examination of it proved

[1] Quoted in the *Medical Press*, Feb. 27, 1889.

[2] Australian Med. Gazette, Feb., 1889.

that it had not changed *its bright color*, but rather increased it, *that it had not become more liquid, and that its corpuscles were perfectly healthy and intact.*

"Next morning I found it congealed like any ordinary blood, and following up the experiment, injected 10 minims of the serum into an old hen. The animal commenced to show the usual symptoms of poisoning in a short time, and was dead in less than two hours. Collecting some of its blood from the left ventricle and the aorta in a second tube, I compared the two. The difference was marked. *The blood from the hen was dark, liquid, and under the microscope presented irregular fragments of broken up corpuscles.*

"In a second experiment I diluted all the poison I could extract from the glands of a brown snake in a test-tube with water containing amœbæ and other infusoria. This I examined from day to day, under the microscope, to find the infusoria not only increasing in number, but actually new forms appearing, which I had not noticed before.

"Accidentally, I have found since that even insects, with a rudimentary nervous system, will revel in the snake-poison. The head of a tiger-snake had been left exposed to the flies in my surgery for a day, and when I took it up for dissection, was found to be alive with maggots. I placed it under an inverted tumbler until the glands and all soft tissues had been thoroughly invaded and mostly consumed. The maggots grew to a large size, and not one of them died.

"From these experiments it may safely be inferred that the snake-poison does not attack and destroy protoplasm, and that if amœbæ and other infusoria live and thrive in a comparatively concentrated solution of it, the blood corpuscles are not likely to succumb to the direct contact with it in the living body, more especially not when they remain entirely unaffected by it in a test-tube under conditions above described. We are therefore driven to the conclusion that by the action of the snake-poison they are placed under conditions incompatible with their healthy normal state and their life, and that these conditions are brought about by functional depression of the vaso-motor nerve centres.

"There appears to be little room for doubt that there are living organisms, *corpuscula viva in corpore vivo*, inhaling oxygen and exhaling carbonic acid; that, in fact, our respiration is but the collective result of their respiration. After whirling through the body and carrying to every tissue the life-sustaining oxygen and the materials it requires, guided by the intelligence that rules the atoms as it rules the worlds, they finally return to the lungs, each carrying a full cargo of effete matter in the form of carbonic acid, to unload it in exchange for a fresh supply of oxygen. But, as I pointed out already, to effect this exchange in the finest capillary vessels, where no doubt it takes place, vessel and corpuscle must touch each other intimately, and for this purpose the vessel must maintain the elasticity and tension which are imparted to it by an uninterrupted and steady supply of motor-nerve force. With this supply taken away or only reduced, the vessel at once gives way to the blood pressure, its lumen becomes larger than the diameter of the corpuscle, and the latter, now surrounded on all sides by serum, is driven on into a vein without effecting its purpose more than partially, if at all. Attracting in its onward course still more carbonic acid, and not getting rid of it when again it arrives in the lungs, it finally dies, literally bursting with carbonic acid. This is the explanation of the blood changes I venture to submit. It has, I am aware, some hypothetical elements in it which orthodox physiology may question, but it is consistent with a theory covering all other phenomena, and for this reason entitled to be maintained as correct until a better one is advanced."

SURGERY.

Keen (W. W.) on Tapping and Irrigation of the Ventricles.—Last fall I made a proposition for tapping the lateral ventricles. At that time I was not aware that the procedure had ever before been suggested, but I have recently learned that in 1881 Wernicke suggested it in a general way, and by the lateral route. I, however, first formulated definite rules, which have stood the test of actual trial. The operation, I believe, was never performed until I did it in a case of marked choked disk on both sides, with complete blindness dating from last Christmas, which I had the opportunity of seeing through the politeness of Dr. Strawbridge. I tapped the ventricle five weeks ago last Fri-

day, reaching it by the lateral route, at a depth of one and three-fourth inches from the dura mater. A half-inch trephine opening was made, a crucial incision in the scalp and dura being employed, as I intended to keep up drainage. From two to four ounces of cerebro-spinal fluid escape from this opening daily.

The case was examined from day to day, to see the effect on the swelling of the optic disks. Before the operation this amounted in one eye to 2.3 mm., and in the other to 1.8 mm. After the operation, it eventually fell to 0.83 mm. on each side. At the end of a week the horse-hair drain, which was introduced at the time of the operation, was substituted by a rubber drainage tube passing into the ventricle. The discharge then became freer, amounting to four to eight ounces per diem.

In addition to this, I explored with a probe the occipital lobe on the left side, twice to a depth of three and a half inches, but found no tumor. I then made a small opening by a gouge under the cerebellum on the left side, and explored the left lobe, and then passed obliquely into the right side, but no tumor was found.

Last Friday I trephined the child on the opposite side, thinking that there might be a tumor in the posterior lobe on that side, but I found none, though I touched the tentorium and the falx. I then tapped the lateral ventricle on that side. Yesterday I washed out the lateral ventricles, passing about eight ounces of a solution of boracic acid (four grains to the ounce) from one side to the other. There was some little irritation resulting from the manipulations, but the moment the warm solution began to pass through the ventricles the child settled itself into a position of complete comfort.

In a bottle of the cerebro-spinal fluid, which has been standing on my desk for a week, there are no signs of decomposition. The fluid contains both sugar and albumin. This, with its continuous flow, proves it to be cerebro-spinal fluid.

The child did not suffer any notable rise of temperature after any of the operations, with the exception of the last one. Then there was a temporary sharp rise to 104°.—*Weekly Med. Rev.*, March 2, 1889.

Solomon (J. V.) on Excision of the Lachrymal Gland in Cases of Epiphora in which Severe Nervous Shock Attends its Treatment by Dilatation.—Surgery is indebted to Percival Pott[1] for advising that stricture of the nasal duct should be submitted to the same principles of treatment as that of the urethra. But it was reserved for Bowman[2] (1851) to devise a method on which the principle enunciated by Pott could be carried into practice *per vias naturales*, and applied to the whole of the tract which constitutes the excretory tear canals. Bowman slit up the canaliculus, thereby making possible the introduction of silver sounds, or probes, of sufficient size and strength to combat strictures, even when rigid, and also certain diseased conditions of the lachrymal mucous membranes. Laforest had previously (1753) invented a probe for the treatment of stricture of the nasal duct, which he introduced through the nostril; this plan, when successful, fails to reach two common seats of stricture, and, as witnessed by the writer in the hands of the late Mr. Wm. Martin, is difficult of performance. A large number of cases of epiphora are successfully treated by Bowman's method, with and without the aid of other remedial agents. But there are some in which a full-sized probe can be easily passed, and where, after a prolonged and carefully conducted mechanical treatment, tears continue to collect and overflow on to the cheek. In some of these, I believe, we have to deal with a chronic œdematous or a flabby condition of the mucous membrane of the nasal duct. The canal readily yields to the pressure of the sound, and on its withdrawal again obstructs the passage. In certain chronic diseases of the cornea, the excretory canals are, on exploration, found free and apparently healthy, the lacrymation being due to irritation of the ophthalmic division of the fifth pair of nerves. The pain and nervous agitation attendant on the modern treatment of stricture of the tear canals vary much, according to the degree of susceptibility of the patient. Some are quite indifferent to the surgeon's proceedings; occasionally, the patient faints on every repetition of the operation. In others, such extreme prostration is prevented by the taking of a stimulating draught. In a recent case which came under my care, a lady of fifty years, of good general health and apparently passive temperament, who had suf-

[1] "Chirurgical Works," 1799, vol. i., p. 343.
[2] Med. Chir. Trans., 1851, vol. xxiv., p. 337.

fered from epiphora of fourteen years' duration, although the process of dilatation was not attended by marked signs of distress, the nervous shock became so great that her health failed, and there was no alternative, in my judgment, but to suspend the mechanical treatment. As the patient expressed herself most anxious to be rid of her epiphora, which gave great discomfort, I proposed to excise the tear gland. This was carried out on the lines advised by Macnamara[1] with complete success. In the cases I have operated upon the incisions have united without suppuration, and the cicatrix soon disappeared sufficiently to escape remark.

The object of this communication is to advise recourse to excision of the lachrymal gland when a serious amount of nervous shock attends Bowman's method. Up to the present the operation of excision has been confined, I believe, to instances of suppuration and dilatation of the lachrymal sac. Such may, according to my experience, be successfully treated by simpler methods, cases of caries being excepted.—*Lancet*, Feb. 23, 1889.

Cotterill on Gangrene of the Colon; Successful Resection.—In the report of the meeting of the Edinburgh Medico-Chirurgical Society, held on December 5th, reference was made to a case of cure, by resection of the intestine, of a fæcal fistula which was the result of extensive gangrene of the transverse colon. The case, which was under the care of Mr. Cotterill, assistant surgeon to the Edinburgh Royal Infirmary, has since been published. The patient was a very stout woman, eighteen stone in weight, and 38 years of age. She had been subject to umbilical hernia for seven years. When seen by Mr. Cotterill she was seven months pregnant. The rupture was a bright red and angry-looking prominence about fourteen inches in diameter. The patient vomited coffee-colored fluid mixed with blood. The sac was opened, and was found to contain a large coil of gangrenous transverse colon, much sloughy omentum, and free from fæculent matter. The gangrene appeared to be due, not to strangulation, but to pressure of the structures in the sac, between the pregnant uterus below and a firm binder which had been worn above. Fifteen inches of colon were cut away, and the ends of the gut were stitched to the edges of the skin-wound. The patient gave birth to a child three days after the operation. For three months after convalescence the patient was troubled with prolapse of the intestine, with discharge of fæces whenever she walked much about. She again put herself under Mr. Cotterill's care. He succeeded in keeping patent both sides of the intestinal tract, and then performed resection. The two cut ends of intestine were freed from adhesions, the upper being first ligatured to avoid the escape of fæces. Traction was then made on the two ends until normal gut, covered with peritoneum, protruded sufficiently for resection. Instead of using a clamp, the operator passed a piece of thin india-rubber tubing through a small hole in the mesentery and round the gut, fixing it there with a pair of catch forceps. Four inches of the upper segment of the colon and three of the lower were then cut away, with portions of mesentery. As the lower segment had been five months in abeyance, it was very narrow and hard to join on to the upper piece. By careful introduction of over a hundred stitches, the ends were brought satisfactorily together. Fine curved needles were used, round, not flattened, and threaded with the finest Chinese twisted silk, and the Czerny-Lembert suture was employed. The cut edges of the mesentery were sutured together, and the gut was returned into the abdomen. The large umbilical opening was brought together by deep silk stitches, and a pad and binder were applied. The operation took three hours. On the third day fæces passed. The patient made a good recovery. No less than twenty-two inches of large intestine were removed in the course of the two operations.—*Br. Med. Jour.*, March 2, 1889.

Franks (K.) on Colectomy for Malignant Disease.—The author records two cases of malignant disease (cylindrical epithelioma) of the colon in which operative measures were employed to remove the tumors. Case I.—A laborer, aged 45, was admitted into hospital on February 12, 1887, suffering from diarrhœa, abdominal pain, pyrexia, and a swelling in the left iliac fossa. An operation was performed on March 18th, when the tumor was found to be a breaking-down epithelioma involving the sigmoid flexure and part of the descending colon. The parietes were implicated. The colon and sigmoid flex-

[1] "Manual of Diseases of the Eye."

ure, with the growth and part of the abdominal wall, were excised; the lower end of gut inverted and closed with sutures, and returned; the upper end of gut brought out at angle of the wound in the loin, and an artificial anus made. The abdominal wound was closed with sutures. The patient died on the sixth day from exhaustion. There was no peritonitis, but the intestines were found in a condition of complete atony. Case II.—J. M., aged 58, came into hospital on October 19, 1888, exhibiting dyspeptic symptoms, diarrhœa, and a remarkably movable tumor below the umbilicus in the middle line. An operation was performed on October 30th, an abdominal incision being made in the linea alba. The tumor was found to be an epithelioma surrounding the transverse colon near the hepatic flexure. The intestine on each side of the tumor was divided; the tumor excised, with several glands, which were enlarged, between the layers of the mesocolon. The divided ends were sutured together with Gély's suture and returned to the abdominal cavity. On the sixth day there was a very copious motion *per anum*, and the bowels acted regularly afterwards. The patient is now in very good health, and has increased much in weight. From a consideration of the cases collected by the author, which had hitherto been published, and which numbered fifty-one, it appeared that the operation had proved fatal in 40.8 per cent. In twenty of those which survived operation, the disease returned in ten, and in the remainder the period which had elapsed was too short to draw conclusions from. One case was alive four years after operation. The author drew the following conclusions: (1) Colectomy rarely effected a cure; (2) as a palliative measure it was justifiable, and frequently demanded; (3) recurrence usually took place in the liver or mesenteric glands, and death then was much easier than when the intestine was occluded; (4) that the mortality after immediate suture of the intestine and after the formation of an artificial anus was nearly equal; (5) that immediate suture of the divided ends was preferable to the formation of an artificial anus; (6) that the death-rate had been reduced in the later cases, and a further reduction might be anticipated.—*Br. Med. Jour.*, March 2, 1889

M'Caw (J.) on a Case of Acute Gonorrhœa Treated by a New Method with Success.—H. J. had impure connection four days before he applied to me for relief. His symptoms were those of acute gonorrhœa, the disease having been considerably aggravated in consequence of his having been drinking heavily both before and since he contracted it. The yellowish-green discharge from the urethra was abundant; he suffered severely during micturition, and there was great tenderness along the whole course of the penile urethra. The night before he came to me he was obliged to rise five times to pass water. He had the disease seven years ago, and was then under treatment for about two months with a medical gentleman in this town, who gave him copaiba.

The line of treatment adopted in this case was by the introduction into the urethra of medicated bougies, and the medicament consisted of sulphate of thallin of five per cent. strength.

Before introducing the bougie I made the patient micturate, in order to clear the urethra of discharge, and I then passed the bougie up to the ring, and directed him to hold the meatus quite close, so that none of the application could flow out as it melted. I kept him lying on his back for twenty minutes, at the end of which time I withdrew the spring and closed the meatus with cotton-wool. During the time the bougie was in the urethra he complained of smarting pain, but after I withdrew the spring he said the pain ceased entirely, and he expressed himself as feeling comfortable. He introduced one every evening after this, following carefully the directions I gave him; and on the third day after he had been with me he called to say he was quite cured, having no discharge of any kind, and no pain on passing water. The day following happened to be his busiest day in the week, as he had to work to 12 o'clock at night, and be on his feet the greater part of that time. In consequence of this he could not use his bougie that day at all, and on the next morning there was a slight return of the former symptoms; but he began anew his treatment, and after using two more bougies, was again perfectly cured. He has remained so since, although he has undergone the heavy day of the week which caused him to relapse before, and this time with impunity. No bad after-effects of any sort resulted from the treatment.—*Dub. Jour. Med. Sci.*, March, 1889.

Whitehead on the Treatment of Confirmed "Catheter Life" by a Permanent Perineal Opening. — His plan he had found to be very effectual, and he believed it to be novel as applied to the advanced stages of prostatic obstruction. The operative part of his plan of treatment differed in no material respect from that of an ordinary median urethrotomy. The originality commenced with the after-treatment, when, through the opening made into the membranous urethra, he retained an india-rubber tube until a sufficient time had elapsed for the fistulous communication with the bladder to become cicatrized. After this the tube was no longer worn continuously; but the patient or his attendant was instructed regularly to withdraw, for an indefinite time, the urine through the fistula by means of a catheter. When cystitis coexisted with enlarged prostate, he recommended that advantage should be taken of each extraction of urine to give the bladder suitable medical irrigation before withdrawing the catheter. Mr. Whitehead mentioned cases illustrating the success of this treatment, and amongst them that of a gentleman now seventy years of age, upon whom he operated in 1884, when there had been symptoms of enlarged prostate, accompanied with cystitis, for ten years previously. The operation was perfectly successful, and the patient, who was incapacitated from business before the operation, had been able to attend regularly ever since, although he continued to withdraw his urine (now quite normal) through the perineal opening. The advantages claimed for this plan of treatment were that the bladder could at pleasure be completely relieved of its contents, it provided a permanent channel through which a perfect could be substituted for an imperfect system of washing out the bladder, and caused six inches of the most sensitive part of the urethra to escape the irritation produced by the passing of a catheter in the ordinary manner. He further contended that, by the maintenance of the permanent perineal opening, the relapses, which almost invariably took place when the aperture was allowed to close, were entirely avoided; and further, that by this means all the inconveniences attending enlarged prostate were permanently arrested without the risks being incurred of a really serious operation. Mr. Whitehead concluded by stating that what he advocated was, perhaps, only a small advance in the direction of what had been practised before; nevertheless, small as it was, it was sufficient to secure advantages which had never been hitherto within the resources of surgery, and that he was under the impression that the cases he had cited were the first on record where bladders had ever been approached through the perineum with the deliberate intention of keeping the openings permanent for the purpose of irrigation.—*Lancet*, March 9, 1889.

BOOK NOTICE.

The Insane in Foreign Countries. By William P. Letchworth, President of the New York State Board of Charities. G. P. Putnam's Sons, Publishers, New York and London, 1889.

This book of 374 pages is beautifully printed and is illustrated by plans of some of the foreign asylums, and by views of interiors, historical pictures, etc.—about twenty illustrations in all. The book is the result of an inspection of foreign asylums and methods of treating the insane made by Mr. Letchworth some years ago. The first chapter is devoted to a survey of the character of management of the insane in the earlier periods of history, previous to the establishment of our modern hospitals and asylums. Separate chapters are given to the institutions of England, of Scotland, of Ireland, and of the Continental countries, and in particular to the colony of Gheel and to the provincial asylum Alt-Scherbitz, near Leipzig. This last institution is well worthy of the eulogy and illustration that the author has given it, as the writer of this critique has testified from his own knowledge ("Some European Asylums," *Am. Jour. of Insanity*, July, 1887). The closing chapter is the most important part of the book for our asylum physicians, trustees, and managers to read, and they will glean from its perusal many valuable ideas and suggestions which will prove of much worth to them in the construction and management of our own home institutions. In this résumé the selection of a site, the location, the character of the buildings, furnishing and decoration, the use and treatment of the grounds, the sewage system, the liberty of patients, the training of attendants, religious exercises, amusements and employment of the insane, dress and diet, the boarding-out system, local and state care, and many other questions, are all discussed with commendable fairness and excellent judgment. In all his recommendations and suggestions, the author avoids extremes; he selects the golden mean, and though there may be some minor points among the many debatable subjects of which he treats wherein a few of his readers will differ from him, yet all will see the earnest philanthropic spirit which pervades and informs the work, and all who have to do with the insane will derive benefit from its perusal. The author is to be congratulated upon the completion of a volume which will be a lasting monument to a life so long devoted to the welfare of the defective classes in our State.

FREDERICK PETERSON, M.D.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Watson (W. Spencer) on the Operation of Removal of the Inferior Turbinated Body, with Cases.—The functions of the inferior turbinated body are: (1) to warm and moisten the inspired air; (2) to intensify the olfactory sense by retarding and disseminating the air currents conveying odorous particles. The removal of obstructing portions of this body is justifiable, unless its bulk can be reduced and its functions restored by less severe methods of treatment. In early stages it is possible to relieve the condition by applications of the galvanic cautery, or nitric acid, or chromic acid. In advanced cases nothing but removal of the growth by the snare is of any avail. The *cautery* snare is but seldom available, because of the difficulty of guiding the wire through the narrowed channel, and because the parts are too moist to permit of complete insulation of the wire. The author employs a twenty per cent. solution of cocaine either in the form of spray to the fauces or by means of cotton-wool plugs saturated with the solution, and passed through the nostrils as well as into the fauces themselves. When removal of bone, as well as of soft parts, is desired, the author recommends the use of his "ring-knife." A single stroke of the "ring-knife," successfully hitched over the posterior end of the turbinated body, will remove the whole of the bone and the membrane with it. The bleeding which ensues is not great, and can easily be checked by the use of small pieces of ice pushed into the nostril. In operating under a general anæsthetic the head of the patient should be allowed to hang down over the side of the table. Notes of three cases, presenting some interesting features, are given, and the paper closes with reflections on the pathology of "petaloid growths" of the inferior turbinated body.—*The Med. Press and Circular*, Dec. 19, 1888.

In the treatment of enlargement of the *middle* turbinated bone an excellent method has been suggested by Dr. Jonathan Wright. It consists of "honeycombing" the bone by perforating it at several points with the electric nasal trephine, after which it may easily be broken with forceps and pressure against the septum is removed. It has the advantage of preserving a considerable part of the turbinated body.—*The Med. Record*, Sept. 8, 1888.

Rice (C. C.) on Antiseptic Nasal Surgery.—The author insists upon the importance of attention to preparatory antiseptic details. He advises copious irrigations of the nose with 1 to 10,000 bichloride solution introduced by means of a post-nasal tube, having a sponge attached near its tip, to prevent the passage of the fluid into the pharynx. Instruments are to be sterilized by immersion in boiling water. The practice of using antiseptic nasal tampons is unsafe. They are irritating, they prevent drainage, and soon lose their antiseptic qualities. It is better to

keep the nostril free, and to keep it as nearly antiseptic as possible by cleansing and antiseptic washes.—*N. Y. Med. Jour.*, March 2, 1889.

Potter (F. H.) on Membranous Rhinitis.—The author's statement that a membranous exudate, covering wholly or in part the inflamed surface, is met with in about two per cent. of all cases of acute rhinitis, will be a surprise to most observers. The symptoms seem to be those of ordinary acute rhinitis intensified, and accompanied by persistent "tickling." The systemic disturbances are not severe. By the third day the membrane begins to form. In many respects it resembles that of diphtheria. An interesting diagnostic point is that cocaine fails to contract the tissues, even when applied to parts denuded of membrane. The duration of the disease, about three weeks, is greater than that of simple rhinitis. A variety of drugs were used by the author without much effect, the best results being obtained from twenty-grain doses of bromide of potash four times in twenty-four hours. Cocaine alone and combined with antipyrin, as suggested by Hinkel, had no effect beyond benumbing the parts. Menthol in one per cent. oily solution was used with benefit. The most relief was obtained from plugging the nostrils for five minutes at a time with dry absorbent cotton. The author is inclined to think that remedial measures are not of much use, except so far as they may diminish the discomfort of the patient, and perhaps hasten convalescence. In conclusion the question is raised whether the prevalent opinion regarding the identity of membranous inflammations of the air passages ought not to be modified by saying that the great *majority* of these cases are related.—*The Jour. of Laryngol. and Rhinol.*, March, 1889.

Hartman (J. H.) on the Treatment of Atrophic Rhinitis with the Galvanic Current.—This method is regarded by the author, as a result of his experience in twenty-one cases, as superior to any which has hitherto been suggested. Results vary, some cases showing improvement at once, while others respond more slowly. His method of application is similar to that advised by Delavan. The positive pole is placed at the nape of the neck, the negative being in contact with the nasal mucous membrane. Mild currents should be used three or four times a week, the length of the sitting depending on the tolerance of the patient. Some will take it for fifteen minutes, others begin to complain in four or five minutes.—*N. Y. Med. Jour.*, March 16, 1889.

Nasal Meningocele.—Dr. Abraham showed, at a meeting of the West London Medico-Chirurgical Society, a man aged thirty-one, with a meningocele occupying the greater part of his nose, and springing from beneath the nasal bones. The tumor was of the same relative size at birth. About six years previously it had been injured by a blow, and had become inflamed. It was lanced by a surgeon, a little blood and "water" escaping; the latter continued to drip for a day or so until the puncture healed. The swelling now measured about 2½ inches in length and in diameter, and exhibited expansile pulsation, a "curve" of which, taken by means of a tambour arrangement and recording cylinder, showed a rapid systolic uprise and a well-marked dicrotic impulse. It did not seem to be much affected by respiration.—*Brit. Med. Jour.*, Feb. 9, 1889.

Cluttan (H. H.) on a Case of Naso-Pharyngeal Tumor Affecting the Base of the Skull; Removal without External Incision; Recovery.—The patient was a boy fourteen years old, who had suffered for eighteen months from impeded respiration and difficulty in swallowing. The tumor, which proved to be a soft fibroma, completely filled the naso-pharynx. It was removed with a Wilde's snare, and the bone to which it was attached (the basilar process of the occipital) was scraped with a sharp spoon. There was recurrence in about a month, and the scraping was repeated much more extensively, masses of soft new growth being scraped away, together with bone, until the sphenoidal sinuses were reached. The vomer and rostrum were broken away with a pair of Löwenberg's forceps, and the whole cavity freely exposed. The operation was very bloody, and the patient was ill for some days. The tissue removed at the second operation had more the appearance of sarcoma, yet there was no recurrence after the lapse of more than two years.—*The Lancet*, Dec. 1, 1888.

In the *Journal of the Am. Medical Ass'n*, Dec. 8, 1888, Dr. E. Fletcher Ingals reports in detail a case of fibroma of the naso-pharynx, upon which he operated with galvano-caustic snare and by electro-

lysis. He refers also to two other cases. When portions of the tumor are inaccessible to the écraseur, cautery, knife, or cutting forceps, we should resort to electrolysis, with which Lincoln has been so successful, in the expectation of at least retarding the growth until the period of adolescence, when spontaneous cure may be effected.

In the *Lancet* of Jan. 26, 1889, Thomas Annandale describes a new operation for the removal of naso-pharyngeal tumors, and reports three cases.

The steps of my operation are as follows: 1. The exposure of the anterior nares by freely dividing the mucous membrane connecting the upper lip and upper jaws, according to the plan of Rougé. 2. The division of the bony septum of the nose along its attachment to the jaw. 3. Incising the soft parts along the middle line of the hard palate, and then sawing through the alveolar margin of the upper jaw and through the entire hard palate along the same line. The soft palate may or may not require division in its middle line. The necessity for this depends upon the size and attachments of the growth. In one of my cases I did not divide it; in the other two I did. 4. The forcible separation of the two jaws, and the introduction through the gap of the finger, periosteal scraper, or other similar instrument, with the view of separating the *secondary* connections of the growth to surrounding parts. 5. The removal of the growth from its primary site of origin by forceps, sharp spoon, cold snare, or galvanic wire. In all my cases I used strong forceps, assisted by a periosteal elevator and a sharp spoon. 6. When the tumor has been removed, the introduction of some form of antiseptic plug. I generally use a plug of lint soaked in carbolic acid, and well dusted with iodoform. 7. The jaws are now brought together again, and secured by one wire suture through the alveolar margin of the bone, and two or more horse-hair sutures through the soft parts of the palate wound.

Vanderpoel (S. O.) on Pharyngeal Mycosis.—The author describes the gross and microscopical appearances of this lesion. In treatment he claims to have had no results from the use of bichloride, or of carbolic, or acetic acids, and only partial success from applications of chromic acid. The galvano-cautery knife repeatedly applied and plunged deeply into the mucous membrane is the only reliable measure. The affection may be differentiated from diphtheria by the absence of febrile disturbance and of inflammation of surrounding tissues, the discrete exudation and its frequent appearance at the base of the tongue. From follicular amygdalitis it may be distinguished by lack of fever and local inflammation and by the difficulty in removing the exudate. The mycosis fungus is much more readily confounded with the concretions so frequent in chronic affections of the tonsils, which in recent cases are soft white masses, but later become hard and chalk-like, and either discharge themselves or go on to the formation of abscess.—*N. Y. Med. Jour.*, Feb. 9, 1889.

In *Rev. méd. de la Suisse rom.*, Jan. 1889, Gautier describes "caseous concretions of the tonsils," but fails to draw clearly the distinction between the conditions just referred to. He relates a case in which he incised and curetted a tonsillar cyst, and afterwards applied chomic acid.

Gavel on Chronic Encysted Abscess of the Tonsil, following Suppurative Amygdalitis. — The author refers to the cases reported by Noquet, Heryng, and Grynfeltt, and describes three cases of his own. He recommends galvano-puncture, of which he also thinks highly in certain cases of hypertrophied tonsils.—*Ann. des mal. du larynx*, etc., Jan., 1889.

Warren (J. C.) on Cancer of the Tongue.—The malignant disease occupied the site of an old recurring specific ulceration, the patient being fifty years of age, and having contracted syphilis some thirty years previously. An instrument for cutting out a cylindrical section of a morbid growth is described, and the advantage of preliminary microscopic examination is noted.—*Boston Med. and Surg. Jour.*, Feb. 14, 1889.

Swain (H. L.) on a Case of Perichondritis of the Cricoid Cartilage, with Paralysis of the Crico-Arytenoideus Posticus Muscles. — The peculiar features of this case are: the long duration of an abscess without dysphagia; signs of perichondritis were not detected with the laryngoscope until after a tracheotomy had been done to relieve the dyspnœa caused by the paralysis; no external change was noticed, although the abscess involved the left half of the cricoid, posteriorly, and had in part destroyed it;

the mode of death was not fully explained, the patient was convalescing from typhoid fever, of rather mild type, when the paralysis of the laryngeal adductors occurred about the fourth week; while still wearing the tube the patient died of tracheal hemorrhage, the exact source of which could not be determined, the abscess not having opened into either larynx or œsophagus.—*Am. Jour. Med. Sci.*, March, 1889.

At a meeting of the Sheffield Medico-Chirurgical Society, Mr. Pye-Smith showed a larynx affected with perichondritis. Elisha R——, a mason, aged forty-eight, had had hoarseness for six months, and attacks of dyspnœa for four days. On laryngoscopic examination, there was great swelling of the right ary-epiglottic fold, the cornicula laryngis being pushed to the left. Tracheotomy was performed, and in a fortnight the swelling had so much subsided that the tube was removed. The wound healed and the patient breathed well for three or four weeks, when dyspnœa returned. Dropsy, with albuminuria, now appeared. Tracheotomy was again performed, but was rendered difficult by the scar tissue and the depth of the trachea (two inches and a quarter from the surface) rendering a specially long tube necessary. The dropsy and nephritis continued, bronchitis followed, then right pleurisy, and finally pericarditis, proving fatal on the eighteenth day after the second operation. At the necropsy three ulcers were found in the larynx, one above and two below the right cord, all communicating with a cavity which lay bare part of the external surface of the ossified cricoid cartilage. There was no history of syphilis. The kidneys, pericardium, and right pleura were inflamed.—*The Lancet*, Jan. 19, 1889.

In the *Brit. Med. Jour.*, June 2, 1888, F. Hollingshead reports a case of recovery after tracheotomy for perichondritis of the larynx.

Cohen (J. S.) on Stricture of the Larynx with Extensive Cicatrization from Ulcerative Tuberculosis.—This remarkably interesting case is reported with very instructive details. The laryngoscopic appearances were very complicated and difficult of interpretation, but the author concluded that the case was one of congenital syphilis, and possibly congenital deformity The sputa were tuberculous, and there were signs of disorganization of much of the left lung and in the upper portion of the right lung. "The picture was the picture of lupus; the cachexia the cachexia of tuberculosis; the diathesis that of scrofulosis." The dyspnœa was relieved by dilatation with Schrœtter's tubes and by exsection of portions of the constricting bands, which were found to contain giant cells and numerous tubercle bacilli. The patient finally succumbed to pulmonary œdema. The pulmonary and laryngeal lesions were found to be very extensive. Both arytenoids were carious and exposed. The resection wounds were in great measure cicatrized.—*Am. Jour. Med. Sci.*, Dec., 1888.

Elman (E. W.) on Hyaline Myxoma of the Right Vocal Cord.—A similar case was reported by this observer in 1886. He believes that the physical characters of hyaline myxoma and of certain cysts of the larynx are identical, and that a positive diagnosis can be made only by microscopic examination. He is inclined to the opinion that this lesion is less rare than has hitherto been supposed. In the present case the growth occupied the upper surface of the right cord at its anterior third. It was the size of a large pea, semi-transparent, pearl-gray in color, with smooth surface, divided into three parts by two horizontal furrows. It was soft, and presented very delicate vascular arborizations on its surface. It was thought to be a cyst, and was removed with Fauvel's forceps.—*Rev. mens. de laryngol*, etc., Feb. 1, 1889.

In the *Lancet*, Sept. 15, 1888, C. W. Hayward describes a case of cyst of the ventricular band treated by incision, ablation of part of the cyst wall, and subsequent applications of nitrate of silver and chloride of zinc.

McBride (P.), Clinical Notes on Fatty Tumors of the Larynx.—The author has found only four instances of this lesion on record. In two cases, those of Wagner and Tobold, the latter of which he has not been able to verify, the growth was not removed during life. In two, those of Bruns and Schrœtter, the tumor was removed with the galvano-caustic loop. Two of his own cases are added. It is hard to understand why some of these should be called tumors of the *larynx*. For example in Wagner's case the growth was attached to the middle line of the tongue and the anterior part of the epiglottis.

McBride's first case was one of fibro-lipoma attached by a broad base to the right vallecula and adjacent part of dorsum linguæ. It was removed in part with scissors, after failure of the cold-wire snare to cut through, for some unexplained reason. The remaining half was removed by means of the galvano-caustic snare. The growth recurred in about a year. It was apparently enucleated by a second operation with the cautery loop. McBride's second cage was also extra-laryngeal, and was attached by a narrow pedicle to the outer part of the right pyriform sinus. It is described as being the size of a bantam's egg, and in the mirror could be seen overlying the left arytenoid cartilage. Sloughing drove it up to a level with the dorsum of the tongue. These growths seem to be characterized by their light-pink color and by the disproportion between their size and the symptoms they produce. The author assumes that removal must be complete in order to obviate recurrence.—*Edinb. Med. Jour.*, Feb., 1889..

Mayland (A. E.) on a Case of Tracheotomy, with Ulceration of the Tube through the Trachea into the Innominate Artery.—Tracheotomy was performed for pressure on the trachea by a spinal abscess, and death ensued subsequently from ulceration of the tracheotomy canula through the trachea into the innominate artery.

The abscess was situated opposite the lower two cervical and upper two dorsal vertebræ, and in its extension forwards had pressed the trachea and œsophagus against the upper part of the sternum, this proving the cause of the obstructive symptoms for which the operation was performed.

(A full account of this case is to be found in the *Annals of Surgery*, 1889.) —*Glasgow Med. Jour.*, Feb., 1889.

THERAPEUTICS.

Atthill (L.) on the Action of Certain Drugs on the Pregnant Uterus.—About fifteen years ago I was asked to see a lady threatened with abortion at about the tenth week of pregnancy. She had been married two years, and during that time had aborted on three previous occasions. I found that she had lost some blood, which continued to come away continuously, but there were no pains; and, on examining her, the os uteri proved to be patulous. She was very nervous, having had sharp hemorrhage on a previous occasion. I came to the conclusion that she would again abort, probably with hemorrhage; and I deemed that the sooner the ovum was expelled the less risk there would be of the occurrence of a dangerous loss. With the view, therefore, of lessening the risk of hemorrhage and exciting the uterus to expel the ovum, I put her on ergot. The result was most satisfactory, but not what books would have led a student to suppose. No uterine action followed on the administration of the ergot, but the hemorrhage gradually lessened. I kept this patient in bed for many weeks, and in due time she gave birth to a son, who still lives and is in robust health.

From that time on I have treated similar cases on the same principle—that is, to patients threatened with abortion, hemorrhage being present, but uterine action, indicated by the occurrence of pains, not having been excited, I administer ergot; these patients are frequently plethoric, with relaxed muscular tissue, and I think it probable that in them the ergot excites a tonic contraction of the muscular tissue of the uterus, which by lessening the blood-supply checks the hemorrhage. In some the ergot excited uterine action, but in all these I had little hope of averting abortion, and believe that it was inevitable. In many, ergot seemed to produce no effect at all, and my belief is that ergot will rarely excite uterine action in cases of threatened abortion, unless the ovum is already blighted and virtually a foreign body. If, therefore, for any reason, the administration of ergot was deemed necessary in the case of a pregnant woman, I should not hesitate to give it. I may add that for many years I was in the habit of administering ergot for several days before the expected date of parturition to patients liable to *post-partum* hemorrhage, with the view of anticipating its occurrence, with very satisfactory results; in no single case did labor set in earlier than was expected, in none did the child suffer in any way, while in two or three cases the occurrence of labor seemed to have been actually delayed by several days. Iron and quinine I have for years administered as freely and in as large doses to pregnant women, as to any other patients, with perfect safety; in

fact, I much doubt whether the ordinary medicines given in ordinary doses have any effect on the utero-ovarian system, whether it be in the case of pregnant women, or taken during the continuance of the menstrual flow.

Personally, I know of no emmenagogue which will cause abortion; ergot, quinine, and strychnine, in ordinary medicinal doses, I am satisfied, will not do so. Savin and rue, etc., I have never ventured to give to pregnant women, because I believed them to be unsafe drugs to administer in such cases; but iron is perfectly innocuous.

I can, without hesitation, say that any of the ordinary tonics, including quinine and strychnine, in ordinary doses, may be safely administered, assuming, of course, that the patient's general health is good. None of them will induce abortion, but neither will any of them have any direct effect either in inducing or retarding the menstrual flow, and perfect general health is not incompatible with even the prolonged suppression of menstruation.—*Br. Med. Jour.*, Feb. 16, 1889.

Clouston (T. S.) on the Use of Hypnotics, Sedatives, and Motor Depressants in the Treatment of Mental Diseases.—The author deduces the following principles of general application:

1. Make up your mind clearly from the symptoms present whether your patient needs a pure hypnotic, a general nervous sedative, or a simple motor depressant before you use any of these drugs.

2. Use all such drugs experimentally in each case at first, and watch their effects not only on the higher nervous functions, but on all the organs and their functions, and on the general organism.

3. Even when there is sleep and quiet produced for the time with no apparently bad results, look to the general feeling of *bien-être*, the recuperative energy, the expression of face and eyes after their use, and see if there is any undue reaction, as if some energy that must have an "outlet" were merely being "suppressed" for the time being.

4. Stop using such drugs as soon as possible, trying experimentally how the patient gets on without them.

5. Keep asking in every case: "Are we sacrificing in any degree the highest functions of mental inhibition by their use?"

6. Never omit general measures for the restoration of the health, nutrition, and higher nervous functions while you use such remedies.

7. Paraldehyde is the purest and least harmful hypnotic yet introduced when the insomnia is marked and intractable. Urethan and sulphonal cannot compare with it. Opium and chloral have special dangers and disadvantages.

8. Use the bromides as accentuators and prolongers of the effects of other drugs, and in order to be able to employ smaller doses than otherwise.

9. A combination of cannabis Indica and the bromides is the best and least harmful of general sedatives.

10. Hyoscine is the best pure motor depressant; but it needs care.

11. We never should narcotize an insane patient, or one threatened with mental disease.

12. It is as dangerous to use more anodynes by the mouth or subcutaneously to relieve mental pain, as to subdue bodily pain by these means only, perhaps more so.

13. It is generally far better therapeutics to enable your patient to bear his mental pain and the effects of his insomnia by improving his general nervous tone and the nutrition of his body, than merely to produce quiet and sleep by drugs.

14. It is commonly a safer thing for the patients, and tends more toward natural recovery from his disease, to provide a physiological outlet for morbid motor energy than merely to depress it directly by drugs.

15. It is almost always preferable to treat cortical exhaustion, irritability, and undue reflex excitability by rest and by improving the fattening and nutrition of the body than by continuous sedatives, the great exceptions being the treatment of epilepsy and convulsive affections by the bromides.—*Am. Jour. Med. Sci.*, April, 1889.

Gordon (J.), a Contribution to the Study of Paraldehyde.—From a very careful experimental study the author draws the following conclusions:

(1) Paraldehyde caused an increase in the excretion of urea. (2) It did not in any marked way affect the quantities of chlorides excreted. (3) It did not invariably increase the excretion of the fluid constituents of urine, but in the majority of cases which I have recorded it diminished them. (4) The odor of paraldehyde,

when given in large doses, was found in the urine, showing that some of it probably passed unchanged through the system. (5) After the full dose of the drug the respirations were slowed and rendered tranquil and steady. (6) It had no appreciable effect on temperature. (7) In cases of average health without sleeplessness it did not have any hypnotic influence except in large doses. (8) It caused no loss of appetite. (9) There was sometimes a tendency to perspiration under its influence, which atropine controlled. (10) The blood-pressure was only slightly reduced by the smaller doses, the large dose reducing it more, but only after distinct slowing of the respiration. (11) The pulse was slowed. (12) It diminished the reflex excitability of the spinal cord. (13) It had a peripheral influence in controlling sensation. (14) It speedily diminished, and in large doses destroyed, the irritability of motor nerves. (15) Equal doses diminished the excitability of motor nerves sooner than that of muscle. (16) Small doses first slightly excited and then diminished the excitability of muscle substance. (17) Large doses speedily destroyed (temporarily) the irritability of muscle substance. (18) There was a tendency to complete recovery in the muscle after a small dose, but seldom complete recovery after a large dose. (19) Curarized muscle showed increased excitability over non-curarized muscle when treated with an equal dose of paraldehyde and equally stimulated.—*Br. Med. Jour.*, March 9, 1889.

Kempf (E. G.) on Cactus, Pulsatilla, and Bromide of Sodium in Some Functional Disorders of the Heart.—The author concludes:

That functional disorders of the heart are, as a rule, symptomatic diseases, and should be treated as such.

That the danger to life is exceedingly small from the heart trouble.

That no strict plan of treatment can be formulated.

That tincture cactus, tincture pulsatilla, and bromide of sodium in combination are useful in some functional disorders of the heart.

Assurance that the disorder is a trivial one should always be given the patient.

Local applications, plasters, sinapisms, ice-bags, etc., may be used with benefit.—*Am. Pract. and News*, March 16, 1889.

Balfour (J. C.) on Actæa Racemosa in Diseases of Nervous Origin.—A rather nervously constituted and not very robust young lady had suffered for years from acute dysmenorrhœa. Menstruation had commenced at the age of twelve, and from the first was attended by great pain and discomfort. All the ordinary domestic remedies were tried without avail, and the patient had to resign herself to being confined to bed for a varying period each month, and to an amount of pain frequently so severe as to cause her to faint. I arrived at the conclusion that the pain was mainly neuralgic (though perhaps partly due to congestion), and I therefore determined to try the actæa, which appears to have a special effect in cases where the uterus and its appendages are implicated. I ordered ten minims of the tincture of cimicifugin to be taken night and morning for a few days before the menses were expected to appear, and to be continued during the whole period. I also ordered the patient to lie down, and to apply hot fomentations or mustard poultices to the abdomen when the pain commenced. From the very beginning of the treatment she experienced great relief, and in a short time found that a dose or two at the commencement of each period sufficed, keeping her so free from pain that only on exceptional occasions was it necessary to lie down for a few hours.

A middle-aged lady suffered from a severe spasmodic pain in the stomach. In conjunction with obstinate dyspepsia, she had acute spasmodic seizures recurring at intervals of a few weeks, and terminating in prolonged fainting fits, sometimes alarming in their severity, as she suffered from an extremely weak heart. After appropriate treatment of the dyspepsia, I ordered ten minims of the tincture of cimicifugin to be given every eight hours in a little water, and continued for a few days, to be recommenced whenever there was any return of the pain or feeling of discomfort. This treatment was so successful that she is now quite free from any return of the severe neuralgic spasm, feels much better, and can eat almost any thing. This patient suffered from a uterine fibroid, with a tendency to prolapse, which may have something to do with the cause of the neuralgia and the success of the actæa treatment.

The third case was a girl of twelve, suffering from great pain in the spine and legs,

and a hyperæsthetic paraplegia of the lower extremities, seemingly of an hysterical nature. I ordered ten-minims doses, of tincture of cimicifugin every six hours, and ten grains of ammonium bromide at bedtime. Relief followed; but pain in the lower part of the abdomen being complained of, mustard poultices were applied over the region of the ovaries. Later, iron was added to the treatment, and complete recovery supervened.—*Lancet*, March 9, 1889.

Bowie (A.) on Nux Vomica in Cardiac Failure.—During the fog which ushered in this year I was asked to see two very marked cases, in each of which death must have speedily occurred but for timely relief.

The first case, a lady aged forty-two, had suffered more or less for three years with bronchitis and mitral stenosis. When I saw the patient her face was pale and anxious and her lips livid; the breathing was short and rapid, and pulsation at the wrist could scarcely be felt; nausea and occasional vomiting of mucus were present, and there was dread of taking food or lying down. The condition had commenced ten hours previously with epigastric pain; but while the other symptoms had increased in severity, the pain seemed to have remained stationary. I prescribed tincture of nux vomica in small doses every half-hour for four doses, then every hour, and there was rapid return to the ordinary condition, although the surroundings and the fog remained for some time as they were before.

The second case was that of a gentleman aged forty-nine, who had suffered for some years from mitral regurgitation and persistent, although mild, bronchitis. Exposure had induced an attack of left lobar pneumonia, which had been running the usual course until the fifth day, when a dense fog occurred in his district. Upon examination his pulse was found to be weak, rapid, irregular, and easily collapsible; his extremities were cold, with clammy perspiration all over his body, and beads of the same upon his livid countenance. He complained of intense pain over the apex of the heart, and his breathing was short and hurried. There was no sickness. His condition had been gradually taking on the above aspect for four or five hours. He had been taking digitalis for two days previously to the attack. This we at once stopped, and substituted tincture of nux vomica, as in the other case, with the result that the patient gradually rallied, and in twenty-four hours had lost his cardiac pain entirely.

I think there can be no doubt that the administration of the nux vomica in the above cases stimulated the motor centres and the ganglionic system to increased activity, and rescued the patients from the consequences of obstructed pulmonary circulation and engorgement of the right heart.—*Lancet*, March 2, 1889.

Strong (E. T.) on Large Doses of Calomel in Pneumonia and Croup.—In the winter of 1885 and 1886, I was led, by an editorial in *The Med. Record*, to try large doses of calomel in croupous pneumonia. The results were so good that I have continued to use it, the number of my cases being now about twenty. All were in the stage of exudation, with high or rising temperature. In age they ranged from eight to over sixty years; in severity, from cases which would have recovered under any treatment, to those that I considered desperate. In every case there was immediate improvement in temperature, respiration, and heart's action, subsidence of the disease in twenty-four hours, and, with one exception, rapid recovery, little or no stimulating or medication being needed. The exception was under most unfavorable surroundings, but was apparently convalescing, when purpura hemorrhagica set in, and the patient died from nasal hemorrhage. My usual and smallest dose was twenty grains every three hours, in most cases continued twenty-four hours. In one case, which I believed would be fatal, the patient took an initial dose of sixty grains, and thirty grains every three hours, until she had taken three hundred and sixty grains. There was no ptyalism in any case, and but moderate catharsis. One of the most remarkable features in every case was the rapid improvement in the heart's action.

I tried the same plan in three cases which I diagnosed as membranous croup. In two, the diagnosis was confirmed by expectoration of shreds of false membrane. In one of these patches of exudation were visible. In the third, an infant of nine months, I was unable to confirm the diagnosis.

All were reported as improving in breathing before the second dose, and all made a rapid recovery. I gave to an in-

fant eighty grains, in ten-grain doses; to a boy of six, one hundred and sixty grains, in twenty-grain doses; and to a boy of twelve only eighty grains, in four doses. I never before had three consecutive recoveries from croup.—*Med. Record*, March 16, 1889.

On the Use of Medicated Wines.—There is a steadily increasing demand for medicated wines. It is found that as regards flavor, and also from the size and frequency of the dose recommended, many so-called medicated wines were intended for beverages, or might easily come to be so employed. The position of the retail chemist is rendered very difficult, since he must now either decline to supply "medicated wines" other than those of the Pharmacopœia, or he must protect himself against the risk of prosecution by taking out a wine license, which would place him in the same category as the ordinary retailers of intoxicating beverages. In the course of some very sensible remarks in this connection in the *Pharmaceutical Journal*, it is shown that this is inconsistent with the nature of a chemist's business, and that it might lead to undesirable development. On the other hand, it is contended that the proprietary makers of medicated wines should bear the onus of meeting the requirements of the excise authorities. Considering the amount of alcohol present in many of these preparations, we should regret any increased facilities for their consumption except under proper medical supervision. It is quite possible that habits of intemperance may be unconsciously fostered by their use; while the plea that the wine is a medicine and that it was obtained from a chemist is very hard to meet. Without questioning the medicinal value of some of these preparations, we would earnestly warn the profession against the risks attendant upon their lavish employment.—Editorial, *Lancet*, March 16, 1889.

Crawford (J. M.) on Dermatitis of Both Eyelids, Brought on by the Application of Tincture of Arnica.—A man of fifty, while drinking, fell and injured his face and eyelids, breaking the skin. Was told by a friend to use pure tincture of arnica. He saturated a cloth with the tincture of arnica diluted, and applying it to his eyes, kept it on for a half hour. Two days after, Dr. Crawford was sent for, and found the lids very much thickened, so much so that he could not raise them, and consequently could not get a view of the eyeballs. Dr. Crawford thought the eyelids to be about one inch in thickness. Two days subsequently, sloughing of the whole integument from eyebrows to tarsal cartilages of both lids took place, and in one eye there were extensive effusion and detachment of the retina. The other eye was not so affected, and was eventually restored to usefulness. Dr. Crawford said that he had never seen or heard of a case of the kind before, but that he knew that arnica was very irritating in full strength, and very dangerous when used about the eyes.—*Atlanta Med. and Surg. Jour.*, March, 1889.

Concerning Collapse from Rectal Injection.—

Editor of THE MEDICAL ANALECTIC:

In your issue of March 14th, in the department devoted to Therapeutics, appears an extract from the *Buffalo Med. and Surg. Jour.*, headed, "Durand (C. F.) on Collapse from Rectal Injection." Under this heading is related the case of a boy, thirteen years of age, who at 8 o'clock in the evening was given an enema containing at least 2½ drachms of pure carbolic acid in a pint of water. Ten minutes afterwards he was in collapse—unconscious, with a pulse of 140, feeble respiration, and cold extremities. It was three o'clock in the morning before he showed any signs of returning consciousness.

This injection is designated as a simple procedure, and the alarming effects which followed it are set down as "due to the irritation of Meissner's plexus." This rather extraordinary opinion may be correct, but a few additional considerations may not be quite superfluous.

And first, although the solution used, 1 to 50, looks very simple and harmless, the fact remains that the pint of fluid used contained more than 2½ drachms of pure carbolic acid—an enormous quantity to introduce into the body of any living human being.

Second, this boy "was of a nervous and excitable disposition," and the susceptibility of such patients to the influence of powerful drugs cannot safely be ignored. The writer was once disagreeably surprised by finding alarming symptoms of poisoning from fifteen drops of the ordinary tincture of aconite root largely diluted with water and applied to the *cervix uteri*, by means of

a pledget of cotton; but the patient was *nervous* and sensitive; and he afterwards found that iodine, carbolic acid, or other pungent fluids, when applied to the interior of the uterus or the cervical canal, were invariably detected by her, by the sense of *taste*, in less than three minutes after the application. Another patient while being nourished by preparations of beef given entirely by the rectum almost immediately tasted the beef when so used, and became disgusted with its taste, as other patients do even when taken for a long time by the mouth. Other patients have been observed who always taste laudanum when used as an enema.

In short, the certainty and rapidity with which liquids, and of course whatever they may hold in solution, are absorbed when introduced into the uterus, vagina, or rectum, is not always fully appreciated.

Third, although an enema, such as was used in the case under consideration, is intended to be quickly expelled, such a result cannot be counted upon with certainty, and even if it should occur, the rectum, and very likely the descending colon, have been distended, and an extensive tract of vigorously absorbing mucous membrane has been inundated by the fluid; besides, under such circumstances, it is quite certain that an important residue of the fluid will be retained and absorbed.

In view of these considerations it would not be unreasonable to expect just what apparently actually occurred in the case under consideration, namely, a nearly fatal case of carbolic-acid poisoning; and to allow such a procedure as was here used to go on record as "so simple," and the alarming after-effects as due to reflex action, is unwarrantable and dangerous.

Some more simple means of dealing with pin-worms should be speedily devised.

R. Osgood Mason, M.D.

MISCELLANY.

Lowrie (J. O.) on Another View of Maternal Impressions.—Since so many have contributed to the literature of birth-marks, and most especially those who believe in the old woman's idea of their cause, I am forced in the vindication of science to break my silence.

It is as utterly impossible for a mother to mark her child in utero as it is for the fowl to mark the young that is in the eggs under her. She may receive such a fright as to cause separation between her and its circulation, thereby producing its premature expulsion. So may the hen get such a fright as to cause her to never return to her nest, and thereby arrest development and cause premature death of the egg. There is practically no difference between them in any respect, and technically none in regard to nerve supply. When we advocate such an unscientific reasoning as the possibility of a mother transmitting nervous impressions to her young in utero, we show to the world that we believe in ghosts and not in the progressive science of our age. The broad presumption made by Dr. LeCrone, in the *Age* of Feb. 11th, is a fair sample of such far-fetched and unphilosophical conclusion—that the child had no head because its mother nursed a sore shin for a few weeks before its birth. I wonder what became of all that brain and bone that had previously formed. The blastodermic membrane, in its division about the third or fourth week of gestation, by some unknown cause failed to give off its third division, which forms the brain. Perhaps an embolus in an artery stopped that part of the fœtal development, thereby the collateral circulation forming a nævus instead of a head.

If our good friend had been disposed to attribute the acephalous child to a nervous impression received from any source, it would have been, I think, far more plausible to have laid it to the father, who, perchance, might have had a few decapitated spermatozoa in his testicles, caused by some newer shock on seeing a decapitated animal (?) Friend L——, ask the father in regard to this, and see if you cannot charge it to the other side of the house, and not blame the poor woman with every thing.

Some months ago I had a case of empyema and a case of perinephritic abcsess, in both of which I aspirated, inserted drainage tubes, and finally made free incision before they recovered, which required no little amount of manipulating, the patients' wives being my only assistants. In both of the cases, both of them being pregnant made them fear some mark would be on their offspring, as they had to pass through ordeals that many men would shrink from. But when the children were born not a spot or blemish could be found about them.

Stop, gentlemen, and think for a moment that there is not the least nerve connection

between mother and child. You are bound to say that the hen or rooster is as capable of impressing its young before they have an independent existence, as the mother or father of the child.

If our Creator had made such possible, scarcely any of us would have been as our Maker intended us to be; for where is a mother that goes through gestation without a fright, like or dislike? Birth-marks are mere coincidences that we cannot understand, but were it possible for us to see the fœtus at any time during its development we no doubt could see that these, to some people, witch footprints would be owing to some disease of the circulation, which often occurs in adult life.—*Medical Age*, March 11, 1889.

Allison on an Improved Method of Amputating the Penis.—The patient having been placed in the lithotomy position, the scrotum split in the middle line, the spongy portion of the urethra divided, separated from the body of the penis, and brought out through the perineal wound, an aneurism needle threaded with stout catgut was passed between the cruræ at their junction, and they were ligatured separately, and the penis removed just in front of the junction; secondly, instead of allowing the posterior segment of the urethra to protrude through the lower corner of the wound, as was done in the first case, and thus necessitated a second operation, the urethral wall was slit up below and the sides united to the skin wound, so as to leave a valvular orifice. A full-sized gum elastic catheter was then passed into the urethra, so as to prevent the urine soaking the dressings. The advantages claimed for this operation were that it was possible to remove the diseased structure more completely. The urethra being brought out in the perineum, there was no dribbling of urine over the front of the scrotum; by ligaturing the cruræ before cutting across the penis no blood was lost. —*Br. Med. Jour.*, March 2, 1889.

Jackson (G. T.) on Prevention of Dermatitis due to Walking or Riding.—Unna recommends washing the parts about to be exposed to attacks of dermatitis, the result of friction from walking or horseback riding, with over fatty ichthyol soap or smearing them with a weak resorcin or ichthyol solution.—*N. Y. Med. Journal*, Mar. 3, 1889.

C. W. C.

Jackson (G. T.) on Treatment of Acne.—The *Gazette des Hôp* gives (1888, No. 112, 1039) the following formula for acne, as prepared by Isaak, of Berlin:

℞.	Resorcin . .	2½ to 5 parts.
	Zinc oxide . .	.
	Starch . . .	ää 5 "
	Vaseline . . .	10 "

M.

The same should be kept applied as constantly as possible. It is said to have a very rapid effect.

—*N. Y. Medical Journal*, March 3, 1889.

C. W. C.

Anderson (McCall) on Differential Diagnosis between Paget's Disease and Eczema of Nipple.

Paget's Disease.

1. Occurs in women over forty years of age.
2. Surface affected, in typical cases, of brilliant red color, raw and granular-looking after removal of crusts.
3. When grasped between the thumb and forefinger, superficial induration often felt, "as if a penny were laid on a soft, elastic surface, and grasped through a piece of cloth."
4. Edge of eruption abrupt and sharply cut, and often elevated.
5. Very obstinate; and only yields to extirpation or other treatment applicable to epithelioma generally.

Eczema of Nipple.

1. Generally in women before the age of forty; especially during lactation.
2. Surface not so red and raw-looking, and not granular, but often punctated.
3. Infiltrated, but no induration.
4. Edge not abrupt. Never elevated.
5. Obstinate sometimes, but yields to treatment appropriate to eczema.—*Buffalo Med. and Surgical Journal*, Feb., 1889.

C. W. C.

Butler-Smythe (A. C.) on Three Cases of Spina Bifida and Hydrocephalus Occurring in the Same Family.—H. T——, aged twenty-nine, married, and mother of five children. Works at dressmaking. Is about five feet in height, rather thin and delicate-looking, though her health is pretty good, and she has never been actually ill in her life. Complexion sallow; hair light; teeth good; no indication of rickets. Pelvis normal. No cough or night-sweats. Never spat

blood. No emaciation. She has had five children, and in each pregnancy went to the full term. All her labors were severe and tedious, and out of five presentations four were abnormal. She never flooded at her confinements, and seems to have convalesced rapidly after each delivery.

The first child had a very large head at birth, and died in nine mouths in convulsions; head swollen and bones separated. The second child had spina bifida in the lumbar region, and was also hydrocephalic. The tumor burst during delivery; the child had fits and died in seven weeks in convulsions. The third child had lumbo-sacral, spina bifida and hydrocephalus. It died in convulsions in three weeks. The fourth child had a large head, and when last seen, at age of 2½ years, the head was still enlarged and the anterior fontanelles open. The fifth child had lumbo-sacral spina bifida and hydrocephalus. The tumor burst during delivery, and the infant wasted away and died in convulsions in five weeks. Her husband is a very delicate man, with bad lungs and a chronic cough; small in build, large-headed, and thick-jointed. The family history shows phthisis on both sides. Two uncles, brothers of her mother, died of consumption, and her husband lost his mother and a brother from the same disease. Neither of the parents suffered from any deformity, and there was no previous history of spina bifidi in either family; but four of the wife's brothers died in infancy, and all of them had enlarged heads. Of five presentations four were pelvic; but in all cases the infants were born alive and lived for some time, though the only child reared was that which had presented with the head. All the infants were suckled. In the second and fifth cases of spina bifida (females) the tumor burst during delivery; whilst in the third case (male) it remained whole up to the death of the infant. In the two instances where the tumor burst, the infants lived some weeks longer than in the case where it remained whole. Beyond the spina bifida and hydrocephalus no other deformities were noticed in any of the infants.—*Lancet*, Feb. 9, 1889.

Williams (J. W.) on a Rare Complication of Labor, Simulating Rupture of the Uterus.—The following case, which I was fortunate enough to see in the wards of Dr. Carl Braun, of Vienna, is certainly worthy of mention, because of its extreme rarity.

A. B., pregnant with her eleventh child, entered the hospital after having been in labor for forty-eight hours. When I saw her, four hours later, she was in a state of collapse and had no labor pains.

On external examination we found that the abdomen, in the umbilical region, was of a yellow hue; and the lower portion of the abdominal cavity and the pelvis were filled with liquid in which the uterus could be freely ballotted *en masse*. The fœtus was dead, and presented by the vertex.

Naturally, from the condition of the patient, Dr. Braun diagnosed either a rupture of the uterus or a rupture of the vessels of the broad ligament.

Owing to the complete inertia uteri and a very small pelvis, craniotomy was performed, and the child extracted by the cranioclast. The placenta was extracted manually, and the interior of the uterus was examined with the utmost care, but no trace of rupture could be found. In view of this fact, the diagnosis of ruptured broad ligament was made, and such diagnosis appeared to be correct at the time.

No exploratory incision was made, and death followed in fourteen hours. The autopsy revealed the pelvis filled with a *large quantity of bile*, which had flowed from a rupture at the junction of the common bile-duct with the hepatic duct, and had produced a general peritonitis, which caused death.

The uterine walls showed no signs of rupture, save at one point, where the uterine peritoneum presented a short linear rent, which, however, did not extend into the muscular layer. No preëxisting inflammation or other cause for the rupture of the bile-ducts could be found.

I report this case on account of its great rarity. So far as I can learn, it is unique; and Dr. Braun states that in all his experience he has never seen or heard of a similar case.

Probably none of us will ever be required to diagnose between an acute hæmatocele and a case similar to this. Should we meet with an apparent case of uterine rupture, and find none, it would be well to remember that the bile-duct has been ruptured during labor with the production of similar symptoms, and that, in the case here reported, the lower part of the abdomen was stained of a yellow color, while the remainder of the surface was of normal appearance.—*Med. News*, Feb. 16, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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THERAPEUTICS.

Amidon (R. W.) on the Uses of Electricity in Medicine.—That a reaction from the old-time credulity of the profession in regard to electro-therapeutics is taking place, the discussion at the last meeting[1] of the New York Academy of Medicine shows.

The enthusiasm which formerly swayed the multitude was imported from France and Germany, and now the ebb of the tide which lays bare the foundation-stones of electro-therapeutics, one of the gentlemen discussing the subject the other night would have us believe, has started from England.

Dr. Starr credited Gowers with being the first to express in print, in his very recent book on nervous diseases, ultra-conservative views on electro-therapeutics. As a firm believer in American common-sense, I protest at any such statement. That some of us eagerly swallowed the Continental bait ten or twelve years ago, I must admit, but that it has taken us twelve years to find out we were sold, I deny. Some of us at once set ourselves to personally and experimentally prove the correctness of the stupendous claims made by Continental electro-therapeutists, with the prompt result of finding most of them a lot of bubbles.

In the spring of 1884 I collected in book form some lectures on electro-therapeutics,[2] which I had been delivering for three years, with other lectures on therapeutics, in the Woman's Medical College of the New York Infirmary. A part of its preface runs thus: "This little book is presented to the medical public chiefly as a protest against the mysticism and charlatanry which have ever hung around the literature and practice of electro-therapeutics. . . . Its (electricity) showiness, its instantaneous and startling physiological effects, and its name, popularly synonymous with life, have long made it, and will long continue to make it, a fashionable remedy, a cure-all for imaginary diseases, a popular placebo, a gold mine for charlatans and symptom-treating physicians, who let their patients make the diagnosis and suggest the treatment.

"Never does the question, 'Was my patient cured, or did he get well?' arise so often as in the practice of electro-therapeutics; other remedies are so often simultaneously employed, the treatment, as a general thing, extends over so many days or months, and so much allowance must always be made for the effect of expectant attention."

On p. 62, in commencing the therapeutic part of the book, will be found the following words: "By far the most brilliant curative results brought about by electricity depend wholly on its power to excite muscular contraction."

Where treating of spinal diseases there will be found, on p. 71, these words: . . . "Electricity, applied externally, has very slight action on the healthy cord, and hardly any undeniable therapeutic effect on it when diseased." Again, concerning cerebral diseases, p. 76: "Electricity, as ordinarily applied to the head, is devoid

[1] March 21, 1889.

[2] "The Student's Manual of Electro-Therapeutics." 12mo, pp. 93. G. P. Putnam's Sons, New York and London, 1884.

of any curative power over any tangible cerebral lesions."

"Contracture of cerebral origin is not very amenable to electrical treatment. . . . Relief, if any follows, is slight and delayed" (p. 80).

As to ocular paralyses, p. 81: "So frequently is this treatment combined with medication, and so slow, as a general thing, is improvement, that the utility of the procedure is questionable."

Concerning spasmodic affections, p. 83: "Tonic spasms, depending on a cerebral or spinal lesion, are not very amenable to direct electrical treatment. . . . Attempts to reach the seat of the lesion by galvanizing the head and back yield no better curative results. A speedy and decided relief of a contracture of a supposed spinal or cerebral origin, would lead me to doubt the correctness of the diagnosis."

Concerning the temporary relief of clonic spasms, p. 84: "A prolongation or repetition of this application, however, is attended by no curative results." Concerning pain, p. 86: "Pains of a cerebral origin, or from disease of the spinal cord (as in sclerosis of the posterior columns), are not amenable to electrical treatment. When caused by acute neuritis also, other remedies are much more indicated. . . . Relief following electrical applications, in pain of obscure causation, often comes from expectant attention, as is proved by the magical effects which often follow the application of electrodes entirely devoid of electricity."

Concerning electrolysis and galvano-cauterization, p. 90: "They should supplant cleaner and more surgical procedures only when the site of the operation is too inaccessible for concise dissection or hæmostasis."

Though not advanced by a European, it would seem as if these ideas were conservative enough, particularly as they were taught and published at a time when everybody else was curing (?) with electricity, locomotor ataxia, progressive muscular atrophy, pseudo-hypertrophic paralysis, glosso-pharyngeal paralysis, tetanus, torticollis, club-foot, aneurism, asthma, exophthalmic goitre, impotence, urethral stricture, epilepsy, melancholia, strabismus, and cataract. One thing which has bolstered up the reputation of electricity as a curative agent more than any thing else, is the extraordinary and utterly fallacious way in which it gets all the credit for results often due to other treatment employed at the same time. Let us cite a few examples.

Says a recent writer[1] on medical electricity: "It is necessary in skin diseases to enforce the most rigid attention to diet, cleanliness, and bowel regularity, before doing any thing else." Pretty good treatment for acne without electricity. Another[2] has cured three cases of epilepsy by a special application of the constant current to the brain, and *the administration of small doses of the bromide of sodium.* (Italics mine.) Another author[3] reports several cases of epilepsy cured (?) by the combined use of the *bromides* and *electricity.* (Italics mine.)

In a case of aortic regurgitation an observer[4] used "general faradization, daily applications, using extreme care over the cardiac region, as any sharpness of current was followed by faintness. *The only medicine employed was lily-of-the-valley tincture. . . .*" (Italics mine.) Very numerous examples of such erroneous deductions could be cited. Another source of error is a failure to properly estimate the proportion of recoveries that take place spontaneously during a prolonged electrical treatment.

An author, speaking of the treatment of acne, says[5]: ". . . It is scarcely worth while to begin a case without some sort of assurance that treatment will be continued at least a year, steadily and faithfully." What changes will mere attention to hygienic details bring about in that space of time! Again, in a case of herpes præputialis the same author says[6]: "Applications were made daily, and after *twenty* the patient was discharged, cured." (Italics mine.)

The same author, with reference to heart disease, says[7]: "I have found daily applications essential to any kind of success, and at least three months' treatment necessary for relief."

The preposterous claims of cure made by some men can be charged to the dense

[1] William F. Hutchinson, in the *Medical Register*, July 30, 1887.
[2] Niermeyer, in *Week. v. h. Nederl. Tijdsch. v. Geneesk*, 1888, II.
[3] A. D. Rockwell, in the *Medical Register*, March 26, 1887.
[4] William F. Hutchinson, in the *Medical Register*, July 23, 1887.
[5] *Ibid.*, July 30, 1887.
[6] *Ibid.*, August 6, 1887.
[7] The *Medical Register*, July 23, 1887.

ignorance, which is mirrored in their writings. As an example, I refer the reader to the following case[1]: "Case III.—G. F. S., a physician, in excellent general health, consulted me for a ptosis of the right eyelid. . . . He was also slightly myopic. The levator muscle was regularly faradized for two weeks, general applications of the same current to the ball being made by the electric eye-cup for the same length of time. He was then obliged to stop treatment by absence from the city, but the ptosis had very much improved, and *the myopia also.*" (Italics mine.) As though the shape of the eyeball could be permanently changed by faradism! The same author claims to cure cataract; while among other diseases which he treats with electricity are capillary bronchitis, acute phthisis, pneumonia, heart disease, angina pectoris, intercostal neuralgia, pleurodynia, hiccough, chronic gastritis, intestinal dyspepsia, rectal stricture, jaundice, and peritonitis. Should one care to study the humorous side of a very serious subject, in the writings of electro-therapeutists he would find a very fertile field.

To exemplify a phase of the subject scrupulously avoided by writers and disputants, the following case[2] of asthma will furnish a text: "Case I.—S. T., aged sixty-four, retired merchant, of hereditary asthmatic history, etc. . . . Treatment was commenced on the 17th of April, 1880, and continued for two months." (The treatment consisted in what the author calls "cerebral alternated with pneumogastric treatment.") "The paroxysms grew shorter and less severe, and the patient became able to take some interest in life once more. At this time, however, unfortunately, he became embarrassed in circumstances, and was obliged to suspend (treatment). . . ."

How pregnant with meaning is this last sentence! Can it be that so potent an agent is good for the rich, but bad for the poor?

I will here make a statement which I have no fear any one will honestly contradict: That ninety per cent. of electrical applications are made either through ignorance or avarice; the latter motive being by far the most common. There is no other way—unless it be the hypodermic treatment of syphilis—whereby a patient can be induced to come to a doctor's office so often, so regularly, and for so long a time as to undergo a thorough "course of electricity." This knavery and humbuggery is rampant all over our land, and in any other profession or business than medicine would be branded as it deserves.

The indications for the use of electricity are just as plain and concise as are those for opium, aloes, or digitalis, and at some future time I should be pleased to present them, but the limits of a letter are already overstepped. Let me add to my readers these words of advice: Don't use electricity without knowing *why* you use it; don't use electricity as a placebo, it takes too much time and is too expensive; and last, but by no means least, don't use electricity simply to make money; it is unprofessional, and brings medicine into disrepute. —*Medical Record*, March 30, 1889.

The Value of Electricity in Therapeutics.—Our readers have doubtless read with interest the letter of Dr. R. W. Amidon in the last issue of *The Record*, and will read, in the present issue, the letter of Dr. Starr, and the courageous criticisms they contain. They will doubtless agree also that, while a good deal of silly stuff has been written regarding the efficacy of electricity, the position of American physicians has not by any means been that of credulity. Over two years ago, in an editorial (*Medical Record*, February 26, 1887), we said: "Electricity has a pain-allaying power, and relieves a number of neuralgic pains. But as to paralysis we are still in the dark. We know that after motor paths are broken in brain, or cord, or periphery, there is a process of separation which follows naturally by certain laws. But do electric currents influence this process of repair? Of this there is as yet absolutely no demonstrative evidence. Some cases seem to begin their improvement with the beginning of electrical treatment, others seem to cease their downward progress under it. But these effects are not uniform, perhaps not even the rule. . . . It is, perhaps, through the psyche that electricity acts in the majority of cases."

Electrical currents have some influence in allaying spasm and in promoting nutrition, and as a mechanical tonic. Their effects are, in the main, mechanical. The chemical and mechanical influence of the current in electrolysis, in stopping hem-

[1] William F. Hutchinson, in the *Medical Register*, June 4, 1887.

[2] Wm. F. Hutchinson in the *Medical Register*, July 23, 1887.

orrhage, in coagulating blood, and in destroying fœtal life, and the reflex effects, have also to be taken into account.

On the whole, while taking a cautious position as to the usefulness of this agent, a position of ultra-scepticism is decidedly unwise. Taken altogether, electricity is not applied as often as it might be with advantage by the general practitioner. It requires time and patience, and a little capital, for its proper use. Nine out of ten of the physicians who read this have no batteries, or those they have are out of order. The dishonest use of electro-therapeutics is something to which many may be tempted, but we cannot believe that such perversion of therapeutics is frequent. The number of persons who persuade patients and themselves that the tri-weekly use of a spray or caustic in the nose and throat, of iodine and glycerine tampons on the cervix uteri, of hypodermatic injections, of inhalation of medicated vapors, is necessary for the recovery of health, must much exceed that of dishonest or incompetent electro-therapeutists, and the number of all classes is, we are sure, small.—Editorial in *Med. Record*, April 6, 1889.

Starr (M. A.) on Electricity as a Therapeutic Agent.—The author sums up the facts presented in his paper as follows:

1. Static electricity offers nothing beyond an interrupted galvanic current, and fails to furnish those effects which are most desirable in the treatment of disease.

2. A constant galvanic current can produce chemical changes which aid nutrition, or destroy tissue according to the strength employed.

3. A constant galvanic current can transfer medicines into the body from without.

4. An interrupted galvanic current, or a faradic current, can excite various organs to functional activity, thereby aiding their nutrition.

5. It is questionable whether the pathological state causing organic diseases can be in any way influenced by electricity.

6. If functional diseases are benefited, it is in an uncertain manner; it being undecided whether it is by influencing the molecular condition, the chemical changes, the circulation, or the electrical state of the organ affected—or by the state of mental expectation induced. The agent is therefore used empirically, and the physiological indications for it are as yet uncertain. As a therapeutic agent its use is very limited, and carefully balanced scientific observations are still needed to establish its proper sphere.

It has been the object of this paper rather to sum up certain facts as opposed to tentative theories than to state any thing new. It is also the object to elicit expressions of opinion of the use of electricity in therapeutics—based upon the experience of those who have given it a careful trial. All reference to the use of electricity in diagnosis has been purposely omitted.

I cannot, however, close without stating that after the constant use of electrical treatment for the past six years in dispensary and in private practice, I have been disappointed in the results obtained. And I cannot ascribe this lack of result to any defect in the applications, for they have been made with care, with the best of apparatus, and with axact galvanometric measurements, according to the methods described by such authorities as Erb, De Watteville, Benedickt, and Beard. My experience coincides with that of Gowers, that the therapeutic effects of electrical applications have been much exaggerated and are really very limited and quite uncertain.—*Med. News*, March 30, 1889.

Starr (M. A.) on the Uses of Electricity in Medicine.—Sir: In a communication which appeared in your columns to-day, Dr. R. W. Amidon makes the following statement regarding the recent discussion at the Academy of Medicine upon the uses of electricity: "Dr. Starr credited Gowers with being the first to express in print, in his very recent book on nervous diseases, ultra-conservative views on electro-therapeutics. As a firm believer in American common-sense, I protest against any such statement. That some of us eagerly swallowed the Continental bait ten or twelve years ago, I must admit, but that it has taken us twelve years to find out we were sold, I deny. Some of us at once set ourselves to personally and experimentally prove the correctness of the stupendous claims made by Continental electro-therapeutists, with the prompt result of finding most of them a lot of bubbles."

After citing his own views published in 1884, in a small volume of ninety pages, entitled "Student's Manual of Electricity," and said to have been delivered in lectures for three years prior to that time, he adds,

"though not advanced by a European, it would seem as if these ideas were conservative enough, particularly as they were taught and published at a time when every body else [!] was curing (?) with electricity locomotor ataxia," etc.

If I have done Dr. Amidon an injustice in omitting to refer to his little brochure, I regret my omission. But admirable in respect of clear and concise statement as that little book is, it does not appear to me to hold the prominent place in the estimation of the medical public which it perhaps deserves. I confess that it had escaped my recollection when preparing my paper. In it the statement is made that "under treatment will be discussed *only* therapeutic applications of electricity which the writer himself has found of undoubted utility in his practice." The work, then, is founded upon a limited experience. It appeared too soon after the larger works of Erb (1882), Dujardin-Beaumetz (1883), Althaus (1883), and others to contain any really critical experimental tests of their assertions, and therefore it had only the value of a controversial statement. And while I am glad to admit that Dr. Amidon's position has been to some extent borne out by the experience of others, yet I think that his statements carry more weight to-day than they did at a time when they were almost prophetic in character. A criticism of any method of treatment can only be fairly made after very long and very patient trial; and a criticism of such measures as are employed in electro-therapeutics must be reserved for years, since it is claimed that it requires years of such treatment to obtain results.

The conclusion reached at the Academy, by the majority of the gentlemen who took part in the discussion, that the field of electro-therapeutics is a narrow one, carries much more weight to-day than it did when reached by Dr. Amidon alone in 1881 or 1884. Yet I regret that I did not mention his opinion in the discussion.

While I do not think that I can be justly accused of an undue bias of opinion in favor of European as opposed to American work, I regret that in the advocacy of "American common-sense" Dr. Amidon should have selected electro-therapeutics; for it is, unfortunately, to American authorities that much that is erroneous in the claims of electro-therapeutics is to be traced. It seems to me that scientific observation should not be hampered by national prejudices, even those which are apparently patriotic.—*Letter to Med. Record*, April 6, 1889.

Chopin (Mlle.) on Elimination of Salicylic Acid in Kidney Diseases.—One result of the administration of salicylic acid is an increase in the quantity of urine excreted and also in the urea, uric acid, and phosphates. The acid appears in the urine within fifteen minutes of its ingestion, and its elimination lasts thirty-eight hours. About eighty per cent. of the amount taken passes off in the urine, part of the remainder being excreted in the form of salicyluric acid. Having ascertained these data by observations conducted on healthy persons, the author then proceeded to compare the results with those obtained in patients with chronic nephritis. The first thing noted was a delay in the appearance of the drug in the urine, this being twenty-five or thirty minutes instead of fifteen, then the total elimination took from fifty-eight to sixty hours instead of thirty-eight. Moreover, the amount of albumen present in the urine of these patients was always increased after the absorption of salicylic acid, and the total amount excreted fell to sixty and even fifty per cent. of the original quantity. It was noted that a very small increase in the dose gave rise to symptoms of intolerence in albuminuric patients and appeared to aggravate the existing renal disease. This fact is a sufficient justification for the measures taken to prevent the use of the acid for preserving articles of food. While the ingestion of a certain quantity of the acid in that way may not be productive of harmful effects in person whose kidneys are in good working order, it is evident that persons suffering from one or other form of renal disease may suffer more or less severely from its admixture with their food.—*Med Press*, March 20, 1889.

Hare (H. A.) on the Value of Soluble Sulphates in Creosote Poisoning.—As a result of experiments, the author has found that in every instance where the magnesium sulphate was given the symptoms of poisoning were modified or almost entirely set aside. This was notably the case in an experiment where the dose was two cubic centimetres to the kilo of the animal, and in another where the dose was four centimetres to the kilo. The symptoms are also seen to be decreased in direct ratio with the increase in size of the

dose of magnesia, being most severe in a case where the proportion of magnesium sulphate to the creosote was only 0.62 grm. to each cubic centimetre, and least severe in a case where the proportion was 2.5 grains to the cubic centimetre.

One other point, than the fact that soluble sulphates are antidotal to creosote, seems worthy of note, namely, that beechwood creosote is not nearly so poisonous as carbolic acid. Thus, one drachm of the latter has caused death in a man of sixty-four years (*London Lancet*, 1869, i.), and in a case of metro-peritonitis fifty drops aided in the production of a fatal issue (*Transactions of the Medical and Chirurgical Society* of Edinburgh, ii., 75), while half an ounce of carbolic acid in a watery solution, applied externally, has produced death (*Schmidt's Jahrbücher*, Bd. clv., p. 276). This fact is also shown by the doses of creosote which are constantly given internally in phthisis and kindred states, and which are much larger than those usually given of carbolic acid.

The conclusion to be reached is that in creosote poisoning any of the soluble sulphates should be given at once in excess. —*University Med. Mag.*, April, 1889.

Williams (A.) on the Influence of Strophanthus on Uterine Hemorrhage.—In strophanthus we have one more drug that can be added to the small number that in any degree control the discharge of blood from the uterus. In properly-selected cases it has a decided influence to stop and control uterine hemorrhage. The cases are such as have been very much debilitated from long-continued and profuse menstruation, or from loss of blood at other than menstrual periods where the uterus is heavily congested—a condition common to these patients. In these it acts well.

In the treatment of these cases it is essentially important that they be made to lie down or be put in bed to rest, for the best results are not obtainable when the woman is allowed to be about.

I think strophanthus acts through its influence on the general circulation, which is that of a heart stimulant or tonic. Through this action on the feeble circulation, found in these cases, blood stasis and local congestions are removed.

It is best administered in the form of a tincture or of powdered seed. Of the tincture (strength 1 to 20) 5 to 6 drops can be given every six hours. Of the powder ¼ to ½ grain, at the same intervals, though I have given as much as one grain with satisfactory results.—*Maryland Med. Jour.*, March 30, 1889.

Rexford (C. M.) on Some Experiences with Sulfonal.—The medicine was employed in a recent case of pneumonia. The attack was not severe; but the patient, a feeble woman, past middle life, was an extremely nervous and difficult one. Great depression of the nervous system came on, with persistent sleeplessness, which proved wholly refractory to ordinary sedatives. A dose of ten grains of sulfonal was given. No effect, besides greater restlessness, was produced for four hours. Then profound sleep ensued, which persisted for twenty-four hours. During this time it was difficult to rouse her enough to take nourishment. No other ill result followed, nor did the insomnia return. The depth of the stupor produced by the small dose employed was such as to make the result of a larger dose seem rather doubtful. This patient has a weak heart, sometimes intermitting, but it seemed not to be affected by the drug.

Another case was one suffering from chronic metritis. This patient, when first seen, was extremely dibilitated by absence of appetite and want of sleep. Fifteen grains of sulfonal at bedtime acted very favorably for a time, but finally failed to induce sleep, and only caused great restlessness instead. Finally, a second dose of fifteen grains was given, four hours after the first. The patient then fell asleep. In the morning she was unable to rise. She complained of giddiness, of being unable to hold the head up, and could not stand or walk without assistance. There was vomiting, and the stomach refused to retain food for many hours. When permitted, she slept a troubled, uneasy sleep for the whole day. It was not till the end of three days that she felt herself again. This patient also has a very weak heart, though there is no organic lesion. She is frequently faint, or is obliged to lie down because the heart acts badly. While under the influence of the medicine, as related, the heart-symptoms seemed to be made somewhat worse, but not notably so.—*Medical Record*, March 30, 1889.

The Treatment of Chlorosis.—It is to be feared that chlorosis is too often treated on the routine principle of giving

iron, without due regard to the ability of the organism to turn the supply to useful account, and without sufficient attention being directed to the collateral condition of the digestive and other systems. It should always be borne in mind that the total amount of iron in the body, in health, does not exceed a drachm or two, and it cannot all have disappeared even in chlorosis. An excess of iron administered by the stomach is only likely to cause gastro-intestinal irritation, and thus lower an already debilitated function. The essential feature of the treatment should be to restore the tone of the digestive organs and to give the iron in a form which admits of assimilation. The preparation answering to this description will vary according to the patient, but, as a rule, the milder the form the more satisfactory will be the effects. In many cases iron fails to produce the hoped-for effects, and then the best thing is to give a mixture consisting of hydrochloric acid with a vegetable bitter, regulating the bowels by means of podophyllin or cascara sagrada, following it up by a course of arsenic. Sometimes manganese proves successful when both arsenic and iron have not been productive of benefit, the binoxide being the most suitable preparation for exhibition. It is hardly necessary to observe that the medicinal treatment must of necessity be subsidiary to general hygiene, and the observance of the maxim, *sublatâ causâ, tollitur effectus.—Med. Press*, March 20, 1889.

The Influence of Phosphorus on Bones.—Ever since the studies of Wegner (*Virchow's Archiv*, June 22, 1872) the profession have generally accepted the results obtained by this investigator. Recently, however, his statements have been somewhat contradicted, and while they have not been proved entirely wrong, some doubt is, of necessity, cast upon the subject.

It will be remembered that Wegner found in adult animals, when fed on phosphorus, a great increase in the size of the bones, the medullary cavity becoming filled, and the entire bony mass much thickened and increased in weight, and that in growing animals the effects were still more marked.

Comparatively recently Kisel, of St. Petersburg, has also studied this question, and his results are so opposed to those of Wegner as to merit attention. He finds, so he asserts, no beneficial influence is ever exerted upon young animals, so far as bony growth is concerned, and that the gastric disorders produced by small doses may produce death.

When given to puppies in the dose of 0.0001 gramme per kilogramme of weight, symptoms of chronic poisoning were produced, with atrophy and disintegration of the tissues, particularly of the bones.

In doses of half this amount the development of the dog was retarded, while such small doses as 0.000033 gramme to the kilo of the animal produced no changes whatever.—*University Med. Mag.*, April, 1889.

MEDICINE AND PATHOLOGY.

Ebermaier (A.) on Disease of the Bones in Typhoid Fever.—In two cases of periostitis, occurring as a complication of typhoid fever, the author was able to prove the presence of the typhoid bacilli in the pus and blood present. The first case was in an eighteen-year-old lad, where, on the thirteenth day of the disease, signs of a periostitis of the second metatarsal bone of the left foot appeared. On the twenty-first day fluctuation was present, and the abscess was opened. The pus was received under proper sterilizing precautions; examination of it showed the presence of a few typhoid bacilli, and cultivation confirmed the microscopic result. The second case was in a nineteen-year-old seamstress, where a periostitis of the right tibia developed during convalescence. The affected spot was incised, no pus obtained, but much blood. Cultivations obtained from this gave the typhoid bacilli. In neither were any other microörganisms found. The author gives six other cases of periostitis occurring during the course of typhoid fever—one of which went on to suppuration, the pus of which, however, was not examined bacteriologically, but he thinks that the results obtained from the two first cases allow us to consider the typhoid bacilli as the causative agent. He considers that the bacilli reach the periosteum from the medullary part of the bone through the Haversian canals, and is led to this belief from having obtained cultures of the typhoid bacilli from the medullary part of a rib removed *post-mortem* from a fatal case of typhoid fever.—*Dutsches Archiv für klinische Medicin.*, *Bd.* 44, 2 *Heft.* W. V.

Kreutzmann (H.) on Acute Mania with Fatal Results Following Ovariotomy.—On the 13th of last October, with assistance, I performed ovariotomy upon a lady who died from acute mania, twelve days after the operation.

The patient was 46 years of age, who previous to her last sickness had always enjoyed good health. Four years ago she was for a short time disturbed in mind, but Dr. Hund could not ascertain exactly what form of insanity the case assumed.

In the beginning of 1887 she noticed an enlargement of the abdomen, complained of dyspnœa and a sense of heaviness, and suffered from occasional darting pains. In June she had an attack of ischuria. At this period the menstruation ceased. The abdomen was large, there was ascites, but nothing else could be felt owing to the tension of the abdominal walls. Four days afterwards Doctor Hund tapped her and withdrew about one half gallon of a rather thick, yellowish-green, clear liquid. For weeks she felt better, but occasionally œdema of the lower extremities was present. The urine did not contain albumen. In the latter part of August she became worse; the dyspnœa increased, the abdomen became larger, her strength failed rapidly, there was no sleep and no appetite. On September 14th, the dyspnœa became alarming, and at 9 P.M. she was tapped the second time, and relieved of at least five gallons of a deeply sanguinolent fluid. At this time on palpation a large tumor was felt. An operation for its removal was advised, but the patient objected until she felt that she was losing strength and getting worse again.

On the day of the operation I saw the woman for the first time. The abdomen was exceedingly enlarged and there was ascites. A tumor could be outlined reaching a point midway between the umbilicus and ensiform appendix. It seemed to be a cystic ovarian tumor, but owing to the ascites and the extreme tension of the abdominal walls it was not possible to make out an accurate diagnosis of its origin.

When the abdomen was opened by a small incision, a large quantity of serosanguinolent fluid slowly escaped; and upon incising the peritoneum we recognized that we had to deal with a very large multilocular cystoma of the right ovary. We furthermore discovered a round opening in that part of the cyst nearest the abdominal wall, produced by a medium-sized trocar. This opening had not healed after the tapping, and through it a creamy-like liquid was flowing freely into the abdominal cavity. This is a very instructive proof of the fact that tapping a cystic abdominal tumor is rather a dangerous undertaking, producing either general or localized peritonitis, which in every instance gives rise to adhesions.

In this case many adhesions were found especially in the pelvic cavity. Yet it was possible to sever most of them with the hand; only a few requiring ligature. Owing, however, to these adhesions we met with considerable bleeding and oozing in the pelvis. We resorted to stitching, ligating, pouring hot (boiled) water into the cavity, and temporary pressure, but were unable to control entirely the bleeding, and, therefore, put a drainage tube into the lower angle of the abdominal wound.

The patient rallied well from the operation and was doing finely. The temperature remained normal. The pulse always ranged between 110 and 120. Dr. Hund stated that this had been the case ever since he first saw her. The quality of the pulse was good. She was catheterized, had passages of flatus and fæces, rested quietly, slept well and enjoyed good appetite. The discharge through the drainage tube was sero-sanguinolent for the first two days, then sero-purulent and very plentiful. The dressings had to be removed twice every day. We pronounced the patient out of danger on the fifth day. On the sixth she was a little less restful, her sleep had not been so very good, but otherwise she was doing as well as could be expected. The next day she was quite the same, but during the night from the 7th to the 8th day after the operation she was taken with a vehement fit of mania. She was violent, cried out, did not recognize her surroundings, sat up and rolled about in bed, jumped from the bed, and tore away the dressings and the drainage tube.

My opinion was that the patient was suffering from acute iodoform intoxication,—iodoform had been dusted in very small quantity on the abdominal wound after the operation. We removed carefully every particle of that drug, and by means of narcotics succeeded in keeping her quiet. The temperature and pulse did not change. We did not insert a drainage tube any more, because the lower angle of the

wound being open it was possible to draw the fluid by means of absorbent cotton. But the patient did not take nourishment, began to sink, and notwithstanding every effort to stimulate her, died on the twelfth day after the operation.

The autopsy, which we were allowed to extend only to the abdomen, revealed a very interesting status. The incision was firmly healed in the upper two-thirds; the lower third was partly open leading to a cavity about the size of a small fist. The cavity in the pelvis was entirely secluded from the abdominal cavity. It contained a sero-sanguinolent fluid in small quantity, and there we found the uterus, left ovary, and the stump of the right ovary. All the organs and the peritoneum in the abdominal cavity were as fresh and healthy as they could be, not the slightest indication of any inflammation being present. The liver was slightly atrophied, the spleen small with soft pulpa; both kidneys, especially the left one, presented the appearance of acute swelling and parenchymatous nephritis.

The question in this case is: Was the acute mania genuine, or was it due to iodoform intoxication? My opinion at first was, that we had to do with an iodoform poisoning. The *confrères* who saw the patient, objected to this, especially because Dr. Hund repeatedly examined the urine and was unable to detect any signs of iodine. Instances of insanity after ovariotomies, in the form of acute mania, have been observed and reported in cases where iodoform had been applied, but only in a very small number. The occurrence of genuine mania after this operation is still more seldom met with.

Considering the very small quantity of iodoform (scarcely a drachm had been used) and the mode of application (only the external wound and surrounding skin had been dusted), I now feel perfectly justified in pronouncing this a case of genuine acute mania.—*Pacif. Med. Jour.*, Feb., 1889.

Ely (J. S.) on Malignant Endocarditis from Urethritis.—After narrating his extremely interesting case, the author says:

Our knowledge of the etiological relation between urethritis and malignant endocarditis and pyæmia may be summarized as follows:

1. Pyæmia has been shown to be due to the presence of the pyogenic bacteria—staphylococcus pyogenes aureus, albus, and citreus, and streptococcus pyogenes.

2. Micro-organisms belonging to this same class have been found in the valvular lesion of malignant endocarditis, and experimental endocarditis in animals has been produced by the inoculation of the same micro-organisms.

3. The complications of gonorrhœa are very numerous, and for their explanation the possibility of introduction of micro-organisms into the general system must be presupposed.

4. In certain cases of mixed gonorrhœal infection of the urethra, pyogenic bacteria have been found along with the gonococci.

5. Nine cases are on record in which malignant general infection occurred in patients suffering from gonorrhœa, and in some of these micro-organisms morphologically identical with the pyogenic bacteria have been found in the urethral discharge as well as in the lesions in the internal organs. In these nine cases the urethra was the only discoverable point of infection.

The case which has been reported is thought to be another of the same nature. Whether the coincidence of the urethritis and the general disease be merely accidental, or whether the one bears an etiological relation to the other, is the question. There is certainly no inherent impossibility in the idea that infection should find entrance to the system through the urethra. Why should not ulcerated urethral mucous membrane offer as good opportunity for the entrance of micro-organisms as ulcerated mucous membrane in other parts of the body? It remains only for some intelligent investigator to prove it in a few cases by a careful study of the micro-organisms found in the various lesions in pure cultures.—*Med. Record*, Mar. 16, 1889.

Parker (J. B.) on a Case of Probable Fæcal Poisoning.—In a case of gastric ulcer, where a limited quantity of milk, hypodermics, and use of the battery failed to afford more than temporary relief, rectal alimentation was substituted, and continued six weeks, when death from starvation threatened. Prompt relief ensued rectal nourishment, but as the patient's strength decreased his bowels could only be moved by a saline enema of tepid water or oil.

On two occasions prior to the resumption of liquid nourishment more freely by

the stomach—necessitated now by extreme debility,—and almost immediately after the receipt of a large tepid enema, suffusion, continuing about thirty minutes, of the head, face and neck occurred, and in a lesser degree, but more in patches, of the body and extremities. The circulation was feeble, without perceptible interruption as before the suffusion, but quickened, which was ascribed to the alarm of the patient and wife.

Recent information in relation to post-enemal fæcal poisoning due to intestinal absorption of poisonous fæcal ptomaines and leucomaines following the administration of tepid enema, which liquefy the fæces and facilitate osmosis, leads to a suspicion that the suffusion mentioned may have been due to poison of this character. After the second, and perhaps more intense, suffusion, the patient complained of sore-throat, evident upon inspection. Some congestion of the fauces, and particularly in the vicinity of the left tonsil, existed, and disappeared in a few days without special treatment. As the patient had not left his bed, certainly not his room, the condition of the throat excited surprise, but was supposed to be catarrhal. If the sore-throat and suffusion were related, as now seems probable, the suspicion of fæcal poisoning is strengthened. The patient regained fair health.—*The Polyclinic*, March, 1889.

Chapin (H. D.) on Septic Poisoning in Early Life.—The author called attention to several often unsuspected sources of blood poisoning in young children, especially to pediculi giving rise to points of ulceration in the scalp. He did not take account of such well-known causes as diphtheria, gonorrhœa, and scarlet-fever, but of lesions of the scalp, mouth, teeth, nose, ears, and umbilical cord from which pus might be absorbed. It often caused an appearance in the child like that resulting from a scrofulous constitution. His experience had convinced him that whenever the glands in the neck were enlarged or ulcerating, search should be made for such a local cause. The lymphatics could dispose of pus up to a certain amount; after this it entered the blood and gave rise to general symptoms, and sometimes abscesses in different parts of the body. In one case related by the reader the rubbing of a nævus with a piece of placenta (an old woman's prescription) had produced general sepsis. Overfeeding and consequent intestinal fermentation gave another class of cases of an equivalent sort. He had been called to see cases of "malaria" in poor families in crowded quarters, and had found children suffering from fever and headache and showing a coated tongue. Investigation of the premises had shown that the practices of the family in the disposal of garbage and bodily excreta were so uncleanly and dilatory that no further cause of illness had been looked for. He had found affections of the respiratory tract, and especially of the tonsils, often resulting from the inhalation of air thus laden with germs. When the lymphatic glands were found to be enlarging it was better not to poultice them with a view to favoring suppuration, but to search carefully for some point where pyogenic germs might have entered.—*N. Y. Med. Jour.*, March 16, 1889.

Rutherford (H.) on a Case of Oblique and Direct Inguinal Hernia on the Same Side.—The specimen which is the subject of the following remarks was obtained from the right side of a man aged fifty-seven, who died in the Western Infirmary of cancer of the liver. There was great enlargement of that organ and distension of the abdomen. It seems probable that this distension was concerned in the production of the herniæ. Some puckering about the internal orifices of both sacs, as well as the distance between the external and internal abdominal rings, and the incomplete character of the internal sac, seemed to point to the recent commencement of their process of formation; while, at the same time, the close connection of the oblique sac with the cord suggested that this might have been originally the patent upper extremity of the processus vaginalis. The sac of the external hernia measured about four inches and a half in length from the deep or internal abdominal ring. It contained a loop of bowel, which slipped back into the abdomen on the scrotum being raised. The internal sac had slightly bulged out the structures lying in front of it, including the conjoined tendon; but in the collapsed state of the parts on the post-mortem table, there was nothing to show its presence, as the parts were seen from without. From within, a protrusion about three quarters of an inch in depth, and freely admitting the tip of the index finger, was seen running downwards, forwards, and somewhat inwards. Its sharp

internal border was formed by a thickening, which was continued upwards on the abdominal wall, running towards the middle line, and which evidently represented the obliterated hypogastric artery. The deep epigastric artery was found in its usual situation immediately to the inside of the internal ring, making a slight curve towards the middle line, as if already somewhat dragged inwards by the neck of the oblique hernia.

The chief point of interest in the preparation was the demonstration which it afforded of the relation of the conjoined tendon to inguinal hernia. The tendon was found inserted not only into the linea alba, crest of the pubis, and commencement of the pectineal line, but into Poupart's ligament as far out as the deep or internal ring, and even beyond it, the outermost fibres curving outwards behind and beneath the cord and neck of the hernial sac. The outer border of the tendon presented a slight thickening, with a suggestion of muscular structure, which appearance, it is to be noted, was not due to a splitting of the fibres of origin of the internal oblique or transversalis, such as has been recorded. —*Lancet*, Feb. 23, 1889.

Saundby on Results of an Autopsy in a Case of Acromegaly.—The result in the main was negative; the pituitary body was absolutely normal; there was no brain tumor, though the brain was deeply congested; the thyroid body was atrophied; there was a sarcomatous mass in each lung, with generalized bronchitis and bronchopneumonia; the peripheral nerves were normal. — *Brit. Med. Jour.*, March 16, 1889.

Wrench on Twenty-Seven Inches of Gut Passed per Anum.—A young man, æt. eighteen, had about the eighteenth day after commencing with abdominal pains, passed a motion which was found to consist of a portion of bowel, with omentum attached. It was a portion of ileum, and measured twenty-seven inches. He remained very ill, but recovery gradually occurred. The treatment consisted in the administration of six-grain doses of morphia every three hours. Mr. Favell and Mr. Jackson referred to cases in their experience —*Med. Press*, March 20, 1889.

A Button-Hook in the Intestines.—Mr. A. B. Kelly reports the following case in the *Lancet*, January 5, 1889: A woman swallowed a steel bow-handled button-hook, three inches and a half in length. On arriving at the patient's house, about a quarter of an hour after the occurrence, I found her seated in a chair, apparently more frightened than hurt. She stated that she had been picking her back teeth with the point of the hook, and the article slipped out of her hand during an act of inspiration and went down her throat. Evidently it had not lodged in the œsophagus, but had descended to the stomach. I requested the patient to assume the recumbent posture, and directed an attendant to administer some bread-and-milk as quickly as possible, and an ounce of castor oil about an hour afterwards. On visiting the patient later on, I learnt that there had been a copious motion, but nothing particular to note. I saw the patient daily afterwards for about a week, she remaining in bed for a few days. There was a daily evacuation, but no sign of the hook. I recommended food consisting of pudding of doughy material, and a moderate allowance of meat, hoping to form a coating round the hook. Further, I gave directions for castor oil every other day, and a mixture of linseed decoction to be administered three or four times daily. Three weeks after the hook was swallowed it passed from her bowels, but without any coating of food. There was, however, a brownish black discoloration over its entire surface.

Mr. E. L. Hussey, in the *Lancet*, January 12, 1889, adds another case: A boy, about seven years of age, sitting at table in the nursery with his young brothers and sisters, was playing with an old button-hook. The wooden handle had long been broken off; only the iron part remained. The nursery-maid told him to put it down. "Shan't," said the boy. Upon her going to take it from him he put it into his mouth, hook foremost, and swallowed it at once. The mother reported the case to me, and asked what was to be done. I advised that all the motions passed by the boy should be examined, and that no purgative medicine of any kind should be given. Three or four days afterwards I was told that the button-hook had been passed per anum without difficulty, and no further inconvenience was found.

Young (J. K.) on the Paraplegia of Pott's Disease.—In July, 1882, the patient, a girl of fifteen, injured her back while working in the field. This was followed by pain in sides and back, abdominal

pains, flatulence, and constipation. These symptoms continued to increase, and in February, 1886, power in the lower limbs was diminished.

On admission, in May, 1886, the patient, a large, well-developed demi-blonde, presented the appearance of good general health. There was a marked kyphosis of the spines of the sixth, seventh, and eighth dorsal vertebræ. There was complete loss of power of both lower limbs. The patellar reflex was greatly exaggerated, and ankle clonus was present on both sides. The sensation was diminished and temperature was normal. She complained of constipation, and pain in the dorsal and hypogastric regions.

She was confined to bed and a Taylor spinal assistant was applied. The patellar reflex quickly diminished, and in less than a week she was able to move about. All the active symptoms rapidly subsided, and when last seen, in September, 1888, the patient was able to walk for miles without fatigue.—*University Med. Mag.*, Mar., 1889.

Shoemaker (G. E.) on Double Mammary Abscess in a Male Infant.—The child X., male, aged four weeks, was brought to the Surgical Dispensary of the University Hospital for an acute inflammation of both mammary glands. The mother applied at the same time with multiple abscess in the right breast. She was young, well-nourished, and of good heredity.

The child, which up to that time had been nursing at both breasts, was plump and well-developed, though there was considerable acute digestive disturbance, as well as fever and restlessness, which were attributed to the condition of its own mammæ. These were both found to be enlarged, hard, and tender, the nipples were prominent, and the skin intensely hyperæmic; giving the boy's chest a curious resemblance to that of a young virgin.

By the fingers the distinct lobes of the glands, separately distended, could readily be made out. Attempted abortive treatment failed, and two days later both breasts were incised at the thinnest point, near the nipple, about two drachms of the thick yellowish pus of acute abscess escaping from each.—*Univers. Med. Mag.*, March, 1889.

McArthur (L. L.) on Surgical Tuberculosis of Bones.—As to treatment the author says: Knowing the nature of tuberculosis better than before, we are now making every effort to totally and completely remove, when operating, the smallest suspicious focus, and, as in operations for carcinoma, to repeat our work at the earliest evidence of a return. When the infective matter has been once thoroughly removed, the chances of a return are not great, though it does occur sometimes in other parts, Billroth stating the propositon that if there has been an early tuberculosis, there will be a return by the age of 50. After operations for tubercular bone disease, too, there has ensued a general miliary tuberculosis. This, however, is as rare as that other phenomenon of bone surgery—fatty embolism of lungs.

It is useless to deny the spontaneous cure of tuberculous osteitis, when we have so many cases of spina ventosa, Pott's disease, and tumor albus that have recovered without treatment. It is useless to deny the tuberculous character of an affection when a successful inoculation has been practised.

The tubercular diathesis does not offer a just objection to operative interference.

Iodoform is the mainstay and sheet anchor in after-treatment.—*North American Practitioner*, March, 1889.

Hunter (R. H. A.) on a Case of Hydronephrosis Relieved by Position.—Mrs. C., aged thirty, consulted me on January 25, 1889, complaining of a painful swelling on her right side, which had been increasing in size during the last three weeks. Upon examination I found a fluctuating tumor, extending from one inch below the lower border of the liver as far as the brim of the true pelvis, forwards to the middle line, backwards to the spine. Passing almost perpendicularly downwards was a deep sulcus dividing the swelling into a large outer and a smaller inner portion. *Per vaginam* I was able to feel the lower border of the cyst. As I was unable to detect the colon, I presumed it rested in the sulcus. Her urine was normal, and other organs healthy. Having diagnosed it a case of hydronephrosis, and thinking that position might afford relief — she having already partaken freely of aperients —I directed her to rest in bed with her pelvis elevated upon pillows. After remaining in this position for a few hours she suddenly felt a desire to pass water, passing about a pint. Shortly afterwards she was again compelled to leave her pillows, and, after passing about a pint and a half of urine, discovered the swelling had disappeared.—*Br. Med. Jour.*, March 2, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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LEADING ARTICLE.

White (W. H.) on the Pathology of the Central Nervous System in Exophthalmic Goitre.—A woman, aged thirty-one, was admitted into Guy's Hospital on September 18, 1888. Her mother died of rheumatic fever at the age of twenty-one. The patient was in St. Mary's Hospital with what she calls ulceration of the bowels. In 1886 she was in bed with the same complaint, and since this illness has never felt really strong. She has been wasting, especially during the last nine months. For the last ten days she has suffered from sickness and inability to take her food. She has had cardiac palpitation for many years. At the age of nineteen she first noticed enlargement of the thyroid.

On admission, is very thin and weak. Eyeballs slightly prominent. Graefe's sign present. Thyroid much enlarged, with a loud murmur over it. She is often faint and giddy; the optic discs are normal; the cardiac impulse is very diffused and heaving; position of the apex normal; pulse 150. There is a loud systolic murmur, heard best over the pulmonary area. Bowels regular; menses irregular; urine normal.

September 21st. She is very sick.

September 23d. This continues, and there is much diarrhœa.

September 25th. Developed signs of pneumonia on the right side, became jaundiced, the sickness and diarrhœa continued, and in spite of treatment she died October 5th.

Necropsy Six Hours after Death.—There is very little fat on the body generally, but there seemed to be quite the normal amount in the orbit. Weight of body fifty-three pounds. Brain weighed forty-seven ounces. The capillaries in its interior were everywhere full, and they seemed especially congested on the floor of the fourth ventricle; optic discs normal; cervical glands slightly enlarged; thymus easily recognized, but not enlarged; thyroid extremely enlarged uniformly; lungs confluent, lobular, pneumonia at both bases; heart, eleven ounces; no microscopical evidences of fatty change; stomach, large and small intestines all intensely congested, with swelling of the mucous membrane; the solitary follicles were prominent, and more so than normal; liver normal, not fatty; mesenteric glands all swollen and injected; suprarenals normal; kidneys normal.

Histological Examination.—Thyroid vessels enlarged and full of blood. There is no increase in the size of the vesicles, but it is evident that many new ones are in process of formation, for there are several of an extremely irregular shape, and also a number of small ones. The whole organ is full of wandering cells of various sizes. Superior cervical ganglia: The nerve-cells are healthy; the sections are crowded with leucocytes. Cervical sympathetic cord: this is quite healty. Spinal cord: a great many sections of this were examined, and save for one or two inconspicuous hemorrhages, which were very small and quite recent, the whole spinal cord was normal. Central nervous system: a series of sec-

tions were made, extending from the lowest point of the medulla up to the corpora quadrigemina. At the level of the lower part of the olivary nucleus there was, just under the posterior surface of the medulla, evidence of slight inflammation, as was shown by engorgement of vessels, a little blood in their sheaths, and a few wandering cells in the posterior median nucleus on each side. The next few sections were quite healthy, but those in the neighborhood of the nucleus of the sixth nerve showed considerable changes. Immediately under the posterior surface of the medulla, extending from the middle line as far out as the restiform bodies, which were slightly implicated, were numerous hemorrhages. The area occupied by these did not extend deeply, so that, except for a slight implication of the sixth nucleus on one side, the nerve cells had escaped damage. Also the fibres of the facial nerve, which come so near the surface here, were free. The hemorrhages seemed almost entirely limited to the posterior superficial part of the reticular formation, but there were two or three small deeper ones. It was at this level that they were most marked, but they existed in all sections up to the lower part of the aqueduct of Sylvius, where, however, only one or two could be seen. They always occupied the posterior part of the reticular formation. The hemorrhages were not old, but probably they did not take place immediately before death, for some of the corpuscles had altered considerably in shape.

I should not have brought forward a single case were it not that I believe this to be the first one recorded in which changes have been found in the central nervous system in association with exophthalmic goitre, and which could also in any way explain it. For a long while the favorite theory to account for this disorder was that the three cardinal symptoms were due to diseases of the cervical sympathetic, but this view is not now held, for often this part of the nervous system has been found to be healthy, or if changes have been discovered they have been such as others and myself [1] have shown to be present in many other maladies; and the specimens from this case quite bear out the refutation of this theory, for lymphatic engorgement of the sympathetic ganglia is met with in the most diverse diseases. Then, also the symptoms of a lesion of the cervical sympathetic and those of exophthalmic goitre bear but little resemblance to each other. Möbius [2] has recently put forward the hypothesis that the disorder is a close ally of myxœdema, and that both have for their cause some chemical disturbance due to the alterations in the thyroid; but I think most will agree with me that this is a very far-fetched theory, for, in the first place, the maladies have hardly any points of resemblance; in the second, they present many striking differences; thirdly, the changes in the thyroid are opposite in the two disorders; fourthly, the analogies of exophthalmic goitre all bring it into relationship with nervous diseases; and lastly, no operations on the thyroid ever produce it. Latterly the idea has been more and more gaining ground that the disease is due to alterations in the central nervous system so fine as to escape detection by ordinary means of observation, and this is supported by many considerations. Often exophthalmic goitre is associated with other nervous disorders. Gowers [3] mentions epilepsy, neuralgia, migraine, and ophthalmoplegia. Savage [4] has shown that it is often connected with mania, general paralysis of the insane, or melancholia. Bristowe [5] has recorded a case of exophthalmic goitre in which there were also present external ophthalmoplegia, hemianæsthesia, epileptic fits, and pyrexia. This patient died, but the necropsy revealed nothing. I have recently seen a case associated with a suicidal tendency, and bearing upon this evidence, there is the remarkable series of cases recorded by Dr. Cheadle, [6] as occurring all in one family.

We should naturally expect to find that the part of the brain diseased was the floor of the fourth ventricle, for there, of all parts of the body, are important nerves and nerve-centres so closely grouped together that we might suspect a lesion in

[1] "On the Pathological History of the Semilunar and Superior Cervical Sympathetic Ganglia," *Trans. of Royal Med. and Chirurg. Soc.*, vol. lxviii., and *Journal of Physiology*, vol. viii., No. 2.

[2] "Ueber das Wesen der Basedow'schen Krankheit.," *Centralblatt für Nervenheilkunde*, 1887, No. 8.

[3] "Diseases of the Nervous System," vol. ii., p. 814.

[4] *Guy's Hospital Reports*, vol. xli., p. 31.

[5] *Brain*, No. 31.

[6] *St. George's Hosp. Rep.*, 1874.

this situation to be capable of causing such diverse symptoms as exophthalmos, thyroid enlargement, and rapidity and palpitation of the heart. In favor of placing the seat of the disease, there is the fact that patients with exophthalmic goitre are particularly liable to die suddenly. A series of cases I published [1] not long ago shows this; and that minute hemorrhages in the floor of the fourth ventricle will cause sudden death is proved by a case [2] (not of exophthalmic goitre) which I have recorded. Sattler [3] is fully of opinion that the origin of the malady is in the medulla, near the origin of the vagus, and points out that probably the lesion is a very slight one, and not always precisely in the same place, for the order in which the symptoms appear is very various, and they are curiously mixed with others. Such a slight lesion, he thinks, might be some vascular alteration, and this is especially probable, as the same symptom varies in intensity from time to time.

Now we come to the direct evidence in support of this view. Filehne [4] operated upon dogs, and cut the upper and inner part of the restiform bodies on both sides with a fine cataract knife. This generally gave rise to one or two of the three cardinal symptoms of exophthalmic goitre; the most frequent was the palpitation and rapidity of the heart; the next the exophthalmos, which was not always equal; but this is probably because the restiform bodies were not equally cut. The thyroid enlargement was rarely obtained, but it was sometimes; and one dog presented all the three symptoms. He considers that the exophthalmos is due to the vascular dilatation within the orbit, for the retinal arteries dilated; and when the protrusion of the eye was on one side only, rapid enucleation of it showed that orbit to contain more blood than the other. Also the exophthalmos could not be caused by the action of Müller's muscle, for it occurred even if the cervical sympathetic were cut.

Naumann [5] has recorded a case in which at the necropsy the basilar artery was found to be brittle and atheromatous, so that the blood supply of the medulla might very well have been interfered with, but he gives no histological description. The changes in the brain described by Geigel [6] were clearly those common in general paralysis, which his patient probably had; so mine, I think, is the first case on record showing definite local changes in the medulla oblongata, and they are in exactly the position in which they might be suspected to be, for we have seen there are strong reasons for placing the seat of the disease in the floor of the fourth ventricle, and the exophthalmic goitre has been attributed to a lesion of the restiform bodies, which were implicated in my case.

No doubt the malady had lasted a long while, and the hemorrhages were only recent, but I can see no inherent improbability in supposing that a diseased part, even if the lesion is not visible, to our means of examination, should be particularly liable to hemorrhage; for we know that as a general rule, diseased structures are more prone to hemorrhage than healthy ones. In connection with this we must remember that Sattler has good reason for thinking the lesion is a vascular alteration, which would usually disappear after death. My interpretation of this case is that the exophthalmic goitre was due to changes in certain parts of the floor of the fourth ventricle, which ordinarily escape detection because they are so fine. We know that in fevers—and this woman had pneumonia—minute hemorrhages in the brain are particularly liable to take place shortly before death. They occurred in this case in the floor of the fourth ventricle; for, being diseased, it was the weakest part of the brain; and thus we have had revealed to us the seat of a disease that has hitherto evaded discovery. I have, like many others, constantly seen capillary hemorrhages which took place in the brain shortly before death, especially in fevers, but I never saw any thing in the medulla at all comparable to the condition we had here. The punctiform hemorrhages were visible to the naked eye, and markedly discolored the floor of the fourth ventricle. No one present at the necropsy had ever seen them so evident in the medulla. Considering it is probable that this is the seat of the disease in exophthalmic goitre, it is diffi-

[1] *Journal*, July 24, 1886.
[2] *Path. Trans.*, vol. xxxiii.
[3] Graefe und Sæmisch, *Handbuch der Augenheilkunde*, Bd. vi.
[4] Communicated to the Physikalisch-Medicinischen Societät zu Erlangen, Sittung vom 14 Juli, 1879.
[5] Sattler, *op. cit.*, p. 981.
[6] "Die Basedow'schen Krankheit," *Würzburg med. Wochenschr.*, vii., S. 70.

cult to believe that the incidence of the hemorrhages here is the result of chance.

In my article in the *Journal* in 1886, I called attention to the frequent enlargement of the lymphatic structures in the intestine in exophthalmic goitre. I have since seen it two or three times; it was present to a slight degree in this case, and it is interesting in this connection to note that the patient had diarrhœa.—*Br. Med. Jour.*, March 30, 1889.

MEDICINE.

Klemperer (G.) on the Dyspepsia of Phthisis.—The author has made a number of examinations of the stomach contents of phthisical patients, presenting digestive disturbances. He divides these cases into two classes—the initial and the terminal stage. The former extending from the time of the appearance of the first symptoms of the disease until the formation of cavities in the lungs; the latter from this time until the death of the patient. A strict division cannot always be made. In the initial stage the symptoms are, heartburn and eructations, nausea, a sense of pressure and fulness in the epigastrium, often pain on pressure over the stomach, and frequent vomiting caused by coughing and independent of eating. A prominent feature is the sudden and capricious changes in the appetite, varying from hunger to a loathing for food. The stomach is of normal capacity, but more or less motor weakness, accompanied in the majority of cases by hyperacidity of its contents, is present. The symptoms presented by the terminal stage are, an absolute loss of appetite; and, contrary to that found in the initial stage, but slight heartburn or pyrosis. Vomiting is independent of the coughing; occurs every two to three days, and is large in amount. The stomach is dilated, and marked diminution both in the secretory and motor functions, with fermentation of the contents, is present. As the author remarks, the picture of a chronic catarrhal inflammation of the stomach is presented to us. From his observations he advises during the initial stage, the administration of drugs which increase the motor strength of the stomach, and these are alcohol in moderate doses and bitters. The best of all, however, he considers to be creosote, and ascribes the good results obtained from the use of this drug to its power of increasing motor activity of the stomach.—*Berlin. klinische Wochenschrift*, 1889, No. 11. W. V.

Westphalen (H.) on Subcutaneous Injections of Blood.—The author reports the result obtained in a case of pernicious anæmia on a man 36 years of age. The symptoms presented were: weakness, marked paleness, poikilocytosis, retinal hemorrhages, and blowing systolic heart murmur. The number of red blood corpuscles was 840,000 in 1 ccm. After iron had been given without improvement, the eggs of bothrio cephalus latus were found in the stools, and the patient was treated with extractum filicis, and the parasites apparently completely removed; no improvement following, the subcutaneous transfusion of blood, as recommended by Von Ziemssen, was made use of; 150 ccm. of defibrinated blood were injected in small portions in several places under the skin of both thighs. Absorption was good, and was not followed by either hæmoglobinuria, albuminuria, or a rise in temperature. On the eighth day after, the number of the red cells had increased to 1,240,000, and four weeks after to 3,636,000 in a cubic centimeter. The poikilocytosis, weakness, and symptoms of severe anæmia disappeared.—*Petersburger. med. Wochenschrift*, 1889, No. 2; noticed in *Centralblatt für die med. Wissenschaft*, 1889, No. 11. W. V.

Anders (J. M.) on a Case of Senile Chorea, with Remarks.—J. B., aged sixty years, occupation cloth-cutter, was admitted to the medical ward of the Episcopal Hospital, August 27, 1888. Patient, prior to present trouble, was in most excellent condition. He has had small-pox, three attacks of gonorrhœa, and acute articular rheumatism, all over thirty years ago. His habits have ever been temperate, though he has occasionally indulged in alcoholic drinks. His father, of sound body, was drowned. His father's brother died of old age, at ninety years, and his mother, prior to death from cholera in 1847, had always been in vigorous health.

He attributed the present attack to exposure while at Atlantic City in July, 1887. One hot night he slept with his head on the sill of an open window; the wind changed, the temperature fell, and he awoke cold, chilly, and suffering with pain and stiffness in the muscles of his neck.

From that morning began the symptoms now complained of. The patient, an American by birth, has always lived in Philadelphia, is five and one half feet tall, and spare, though as well nourished as he has ever been. He comes complaining of his inability to keep at rest while awake, of oft-recurring attacks of fidgets. The attacks have so increased in severity and frequency as to compel cessation from work. There is a slightly increased prominence of the nape of the neck, though no actual deformity of the cervical portion of the spinal column is discernible, and his head is constantly held more rigidly erect than would be naturally expected of a man of his age. During an attack the muscles of the neck, back, and chest undergo irregular spasmodic contractions, causing shrugging of shoulders, twitching of arms, and well-marked jerking of head, which is thrown in the backward direction. The face also is thrown into movement, and exhibits characteristic choreic grimaces, with rolling of eyeballs. As the attack proceeds the diaphragm becomes similarly affected, causing great difficulty in breathing. Inspirations are jerky and irregular. The accompanying dyspnœa is always a most prominent and distressing symptom. During the attack great pain is felt in the back of the head and neck. Each exacerbation lasts from one to four hours. During the intervals he feels quite well, and has only an occasional involuntary twitch. Insomnia is very great, and night follows night before he procures refreshing sleep. The intervals of quiet vary considerably in length ; one, two, three, or more days may intervene between these attacks. His appetite is fair, and his digestive functions are performed with apparent vigor and regularity. The action of the heart is constantly rapid, the pulse rate ranging from 110 to 120 per minute, but there are no evidences of organic valvular disease detectable. Neither are there any characteristic subjective or objective symptoms present pointing to any nervous trouble other than chorea. There is no dementia.

When admitted he was placed on a mixture of quinia, iron, and strychnia ; also was given ten grains of bromide of potassium every three hours. This treatment was continued for three weeks without benefit. Arsenic, which was administered both by the gastro-intestinal route and hypodermically, proved valueless, as did also antifebrin given in doses of grs. iv. every three hours. During the attacks hypodermic injections of morphia afforded relief, causing sleep. The hydrobromate of hyoscin seemed to have a beneficial effect when first used, though soon it lost its virtue.

Dr. Russell relates a case that recovered at the expiration of three months from the use of sulphate of zinc.

Dr. Sinkler reported two cases, one of which recovered in four months. Still another case, first seen by Dr. Saundby when the patient was fifty years of age, suffering from left-sided chorea of an intermittent form, again fell under hi. observation when sixty-six years old, and at this time was almost cured.

The two cases reported by Charcot[1] were demented ; also a case reported by E. J. Davis,[2] and still another by M. Bacon, in which instance the patient had chronic mania.[3] Thus, in a total of thirteen recorded cases, in all of which the mental condition was noted, four were demented —less than one third.

Dr. Saundby saw three patients suffering from this disease, all of whom had advanced degeneration of the arteries. This observer believes "that it will be found that the pathology of this disease is some actual structural change, such as small hemorrhages in the corpus striatum, and that it is not merely a functional derangement." In my own case there were present evidences of commencing atheroma. Of all the collectable cases, only four showed this condition—too small a proportion to base thereon positive conclusions.

The influence of sex may be shown to be considerable, since in eleven of the thirteen cases reported, the sex has been noted, and of these eight were males, three females. This would appear to be an exact reversal of the influence of sex in chorea occurring among children, for in the latter, according to the statistics of Dr. Wharton Sinkler and others, the ratio is about three to one in favor of the female sex.

Of the thirteen cases, only three were associated with heart disease, a fact showing but a feeble, if any, connection between senile chorea and cardiac affections. Not

[1] *Medical Times and Gazette*, 1873, vol. i., p. 245.
[2] "Case of Chorea in the Aged," *Medical Times and Gazette*, vol. ii., p. 247.
[3] *Lancet*, Nov. 24, 1884.

more than two of the total number gave a history of previous rheumatism. A final point to be made is that any theory as to the pathology of chorea in the aged, based upon the meagre data at present attainable, must be purely speculative.—*Cincin. Lancet-Clinic*, April 6, 1889.

Walker (T. J.) on the Clinical Significance of Colorless or Clay-colored Stools Unaccompanied by Jaundice, and their Connection with Disease of the Pancreas; and on the Part Played by the Pancreas in Eliminating Bile from the Intestines.—After referring to the accepted views of the significance of clay-colored stools, the author gave particulars of two cases in which, during life, a persistent symptom was the absence of color in the fæces, and in which the diagnosis made of obstruction of the pancreatic duct, with a healthy condition of the bile-duct, was confirmed by the necropsy. From these cases, Dr. Walker concluded, first, that the formation of hydrobilirubin, the coloring matter of the fæces, depended on the mutual reaction of the bile and pancreatic fluid, under the influences met with in the intestinal tract; secondly, that in disease a deficiency of pancreatic fluid would, equally with a deficiency of bile, cause the pathological condition of colorless or clay-colored stools; thirdly, that since, according to the most recent physiological researches, that portion only of the colored constituents of the bile which had been converted into hydrobilirubin was excreted in the fæces, while the unchanged bilirubin, bilifuscin, and biliverdin were absorbed, it followed that, if hydrobilirubin could not be produced without the aid of the pancreas, that organ must have an important *rôle* in regulating what proportion of the bile entering the intestines should be absorbed and what thrown off in the fæces. Dr. Walker then pointed out that these conclusions received confirmation from the records of other published cases, that Claude Bernard recognized that the pancreas had a part in causing the color of the fæces, and that the state in which the bile pigments were found in the meconium of the fœtus, while the pancreatic function was in abeyance, also accorded with these conclusions. He further pointed out that the fact of the pancreas influencing the excretion of the bile in the fæces would, if accepted, reconcile the discrepancy between the clinical observation that certain drugs produced copious bilious stools, and the physiological observation that these drugs had little or no influence on the secretion of bile by the liver, and that the same fact would explain those hitherto inexplicable cases in which, with no evidence of arrest of the bile-secreting functions of the liver, or of obstruction of its ducts, the symptom of white or clay-colored stools was persistently present. In conclusion, Dr. Walker indicated the practical importance of the views he had endeavored to establish in the treatment and diagnosis of pancreatic disease and of all forms of bilious disorder.—*Br. Med. Jour.*, March 30, 1889.

Reynolds (J. P.) on the Treatment of Spasmodic Croup.—I esteem the emetic as an indispensable introduction to the treatment of *all* cases. Almost invariably the last meal taken is found to be cast up undigested, and oftentimes food that has been taken twelve hours or more before the administration of the emetic. I regard this condition of the stomach as bearing a causative relation, by reflex action, to the laryngismus, and hence administer the emetic *at once*, whether or no the dyspnœa be urgent. Ipecac, I think, is the best emetic for this purpose. It is reliable and mild in its action. When emesis has ceased, I give from two to four grains of quinine, and as large a dose of the *fluid extract of gelsemium* as the age of the child will justify, generally from five to ten drops. The following morning I have the patient take a dose of castor-oil to open the bowels freely, and continue small doses of the gelsemium throughout the day—two drops every two hours. Another full dose of gelsemium and quinine on the second night at bedtime will be effectual in preventing any further paroxysm.

I find imperfect bowel action so commonly preceding these cases, and digestive incompetence or perversion accompanying them, that complete evacuation of the *primæ viæ* seems to me always to be rationally indicated. The administration of opium, as recommended by Dr. Meigs, may subdue the laryngismus by reducing the perceptive power of the nerve centres to morbid irritation, but at the same time the overloaded alimentary canal is rended *more* inactive, and the digestive disturbance is ignored. These conditions of functional inactivity and perversion are my main

points of attack. I regard the laryngismus as their reflex expression or effect upon the sensitive nervous system of the child, and find gelsemium and quinine adequate to allay it.—*Med. News*, April 13, 1889.

Powell (D. F.) on Naso-pharyngeal Catarrh.—In naso-pharyngeal catarrh and ozena and other catarrhal conditions I have found the following of value :

Take of re-sublimed iodine four drams ; carbolic acid and chloroform, each half a fluid ounce ; tannic acid, one ounce. Thoroughly triturate the iodine and tannic together until they become intimately mixed and in fine powder, then gradually add the chloroform and carbolic acid (previously mixed) and thoroughly incorporate the whole.

Then take fluid ext. hemlock, spruce, (abies Canad.) eight fluid ounces; fluid ext. wild indigo (baptisia tinct.) one fluid ounce ; fluid ext. stramonium leaves, four fluid drams ; solution boro-glyceride (5 %), four fluid ounces. Evaporate the fluid extracts mixed with the boro-glyceride (in an evaporating dish, with water bath) until the whole measures six fluid ounces, then thoroughly mix with the iodine, tannin, and acid.

This may be applied to the nostrils, throat, tonsils, or uvula, with a camel-hair pencil every other day. While using it a snuff composed two parts finely-powdered slippery elm, mixed with one part each of powdered starch and sodium bicarbonate will be found useful. For ulcerations, fissures or erosions of the cervix it is best applied on pledgets of absorbent cotton. These pledgets should be removed at the expiration of twenty-four hours and a tampon of absorbent cotton (as large a butternut) soaked in pure glycerin, be substituted. Two applications a week will work wonders if continued for a month or more.—*Med. Standard.*

PATHOLOGY.

Holmes (B.) on Cultures of Bacteria from the Urine of a Case of Nephritis after Scarlet-Fever.—Through the kindness of a neighbor physician I had a chance to examine the urine of a case of nephritis after scarlatina, and to make a few cultures from it. On the first day that any symptom of nephritis was noticed there was a very large amount of blood in the urine, and I took pains to collect some of it in a perfectly sterilized flask after the first part had passed away, so as to get it in as nearly a sterile condition as possible. I took it home and planted the sediment in a few tubes of gelatin. The gelatin in a very short time showed small colonies growing along the track of the needle. From isolated colonies the second series of tubes was planted, and they begin to show a characteristic growth. Only one of the first series of six tubes remains sterile, and only two of them begin to show any signs of mixed infection. The remaining three tubes are evidently pure cultures of the *Streptococcus pyogenes* of Rosenbach. This is the microbe that produces the enlargement of the cervical lymphatics early in scarlet-fever. — *Chicago Med. Jour., and Ex.*, Jan., 1889.

Acheson (G.) on Uræmia.—The directions in which the solution of this problem should be sought are, according to the author, the careful study of the microchemistry of the tissues, and especially of tissue metabolism, and the by-products of nutrition, and the investigation of the interrelation of different organs, *e. g.*, kidney and thyroid, thyroid and brain. We know, for instance, that there is an important physiological relationship between the brain and the thyroid body in connection with cretinism and mucinogenesis ; but we know nothing yet of the relationship between the thyroid body and the kidney, or what are the changes, nutritive or otherwise, that may be produced in the former when the latter is not performing its normal functions.

A most careful study of the brain and cord by the latest improved methods of microscopic technique will probably demonstrate that there are structural lesions of the nerve-centres in many or all of the cases.

Perhaps it is not unreasonable to suggest that epilepsy and other so-called neuroses may depend on the presence of poisons in the blood circulating through the nerve-centres, and that there may be structural lesions which have hitherto been undetected ; nor should we rest satisfied until we have exhausted every means for disproving that any disease is merely functional.—*Canad. Practitioner*, April 1, 1889.

The Passage of Microbes Through the Skin.—In the course of some experiments with bacilli obtained from rabbits suffering from "intestinal diphtheria," M.

Ribbert noticed that when an emulsion containing them was introduced into the mouths of animals they died with enlarged glands in the neck, and the bacilli could be detected in the parenchyma of the tonsils. He concluded that the tonsillar tissue lent itself to the passage of the bacilli. Another observer has gone a step further, and has succeeded in infecting animals with the *staphylococcus aureus* by merely rubbing it into the skin with or without an excipient, such as lanoline, lard, or olive oil. He found that the use of either excipient favored the penetration of the bacilli. It would seem, therefore, that the skin, even if intact, does not afford absolute protection against the invasion of certain bacilli. The possibility of minute lesions of the skin being produced by the rubbing was negatived by subsequent microscopical examination. The next step will be to endeavor to ascertain the particular structure through which the bacillus finds its way in its passage through the skin, by means of microscopical sections made at different periods of inoculation.—*Med. Press*, March 27, 1889.

Formad on a Case of Sudden Death in a Pregnant Woman.—The patient was a woman of twenty-eight, pregnant for the first time. Shortly after marriage she grew quite fat. She had never complained. She went up stairs, a woman in the house heard a shriek, found her in a convulsion, and in a few minutes she was dead. There were large white kidneys; the bladder was empty; the blood fluid; the brain highly anæmic. There was general dropsy and extensive hydropericardium and hydrothorax. The case illustrated the great danger a woman who has Bright's disease runs in marrying and attempting to bear children, and is interesting on account that so extensive a hydrothorax should give rise to no symptoms.

Tyson believes a girl of eighteen or twenty with Bright's disease is almost certain to die with her first child. He has heard lately of a single instance where death did not occur, but he has no history of the case. He has saved, he thought, life in at least one instance by advising against marriage where the woman had albuminuria. With regard to the presence or absence of symptoms in cases of filled pleural cavities, a close examination will disclose symptoms, but occurring in phlegmatic persons no complaint is made. When the pleural sac is so filled death must be cardiac. As to the cause of death in albuminuria without previous symptoms, he has often asked himself the question; it is unexplained except that we may say that the uræmic poison acts as any other poison. Osler says this much is certain, that no acute full effusion in both pleural sacs can exist without symptoms. If it occurs rapidly it produces death rapidly. The effusion may take place slowly and be supported for some time. There need be no reason for surprise at the death in this case. This woman has had the ordinary nephritis of pregnancy. Death may occur in the first uræmic convulsion as well as later, but the exact cause of death from uræmia we have yet to ascertain. Musser thinks hydrothorax one of the most common causes of death in patients with chronic illnesses. We go to the bed, the patient is breathing a little hurriedly, or is off his appetite, but does not complain, and hydrothorax is found. This condition seems usually to develop after a change in the weather.—*University Med. Mag.*, April, 1889.

De Wees (W. B.) on Fetid Menstruation.—The natural odor of the menstrual discharge is peculiar, but not offensive. It is an odor *sui generis*, and has been compared to that of the marigold (*calendula officinalis*), fish brine, etc. It is most pungent in women of darker or lighter complexion, *e. g.*, in negro and in red-haired women it is often very strong. Virchow attributes it to the presence of fatty acids. But it is not the peculiar natural odor pervading menstruants that we wish to bring to the attention of the reader. It is the abnormal odor contracted by the flux at or before it emerges from the uterus. To differentiate the two in all cases may become difficult, but the distinction must be borne in mind while endeavoring to make a proper diagnosis.

Every physician of experience no doubt has had a number of cases of fetid menstruation—*fluxus menstrualis fœtidus*—for which I would propose, in accordance with scientific nomenclature or nosology, the name of fœteo-menorrhœa—and found them to arise from very different causes.

The disordered conditions are of *general* or *local* origin. Not infrequently both are combined. To the class of general origin belong all impaired blood conditions—chlorosis, syphilis, etc. To the class of

local origin belong: (1) prolonged retention and decomposition of the menses; (2) the discharges in certain morbid conditions and growths within the body of the uterus.

In chlorosis the catamenia is of a feeble type, and scanty, even if regular, the discharge is very pale, and in a large percentage of the cases it is greenish in color. It is in those cases presenting this greenish discharge that fœtidity is apt to occur. In these cases the offensiveness is evidently due to the degraded blood-condition, for when this is corrected it subsides. The same principle holds good in cases due to simple anæmia, syphilis, etc.

Prolonged detention and decomposition of the catamenia may be produced by either mechanical obstruction, principally stenosis or flexion, or to deficient expulsive power of the uterus, both of which are often accompanied by a scanty flow. Many of the most severe and obstinate cases of fœteo-menorhœa are due to diseases of the endometrium—in subinvolution, particularly of the placental site—after abortions and confinements; polypi, fibroids, epitheliomata, sarcomata, papillomata, etc. Occasionally cases present themselves evidently due to the gonorrhœal poison.

It is worthy of mention that four very obstinate cases of this kind have been treated by the writer during the past year. The catamenia in these four wives were not only very fetid, but equally acrid, which seemed to excite a villous proliferation of the endometrium, with a virulent discharge in the interim of the epochs, being most obstinate and persistent, as well as difficult of cure—producing excoriation of vagina, vulva, and parts with which the discharge came in contact of each of these four women, while in each of the four husbands they brought on perpetual attacks of urethritis. The cases were cured eventually by radical erasion and cauterization of the endometrium in each uterus, and by appropriate treatment of the husbands, together with enforced abstinence from intercourse for a definite time. Each any every one of these four men had primarily contracted clap, and conveyed the same to their wives, followed by the results above delineated, the wives being free from fœteo-menorrhœa prior to and since said infections.

As regards local measures other than operative procedures (such as erasion, removal of morbid growths and dilatations), injections and irrigations, with deodorizing materials, are very useful. Solutions of boracic acid, corrosive sublimate (1:2000), carbolic acid, iodine (1 to 40), and, what I prefer to all of them, boro-glyceride and Listerine, in from 25 to 50 per cent. solutions. The general treatment in chlorosis, anæmia, and other impaired blood conditions is chiefly to be overcome by the judicious use of arsenic, iron, and quinine, while in syphilis iodide of potassium must remain our chief reliance.

Last, but not least, healthful, nutritious diet, open-air exercise, proper and free use of water as drink and bath, sunlight freely welcomed, pleasant surroundings, cheerful society, etc., must always receive due recognition.—*Fr. Am. Med. Ass'n*, Feb. 16, 1889.

A Cause of Biliary Calculi in Women.—Marchand finds in women's stays a frequent cause of the formation of gallstones. The pressure exerted by these articles of dress on the liver is transferred to the gall bladder and its ducts. This pressure is not uniform; it is more constant by day, but decreases at night, or is exerted only when the form of the thorax is already altered by pressure. This pressure causes the retention of the bile in the gall bladder. During the daytime the bladder tends to empty itself; in the intervals of digestion, and during the night, there is a tendency to refill itself. If the daily evacuation of this organ is prevented, or only imperfectly effected, there is a recurrence of stagnation of bile, and consequent disposition to the formation of gallstones.—*Med. Press*, March 20, 1889.

SURGERY.

Andrews (E.) on the Antiseptic Value of Boric Acid.—It will be noticed that while others allege that they have found micrococci living in saturated solutions, I have been unable to discover any in solutions stronger than one per centum.

From my experiments it is evident that the saturated solution of boric acid in ordinary use among us is abundantly antiseptic, so far as preventing putrefation is concerned, but that it does not prevent the growth of mycelium of, at least, some species, and probably does not prevent the development of every species of bacteria and micrococci. We may conclude, there-

fore, that while boric acid, in all probability, is a good antiseptic for practical purposes, we have not a certainty that every injurious microörganism will be destroyed by it. In short, it lacks the all-conquering energy of the corrosive sublimate solutions. We may conclude with reasonable certainty that, used in a dry form to pack foul ulcers and septic wounds, it will be of decided value on account of not only its antiseptic power, but also its freedom from any caustic or irritating qualities.

The presence of glycerine seemed to increase the efficiency, so that even the mycelium did not appear. My final conclusion is that for a multitude of purposes boric acid is a very valuable article, and convenient for use on account of its cleanliness, freedom from odor, and the total absence of any caustic or irritant qualities, but that in the present state of our knowledge it is not safe to rely upon it exclusively in cases which demand the most decisive and energetic antiseptic qualities. In short, where life is at stake, and may be dependent, to a great extent, on the energy of the antiseptic, it is better at present not to repose too implicit a confidence in boric acid.—*Chicago Med. Jour. and Ex.*, March, 1889.

Prince (D.) on Boric Acid and Oil of Cacia as Wound Dressings.—The ideal of a surgical dressing implies :

1. An agent which is not irritating.

1. One which will absorb any fluids that may escape and form a compound with them capable of resisting the ferments of the air.

3. One which will allow no neutral under surface where putrefactive changes may creep along the skin under the dressing and carry infection from without to a wound not completely closed.

These points can be affirmed of no substance which becomes solid or is completely insoluble. They cannot be affirmed of any gauze, or absorbent cotton, or wool, for all of these are capable of forming compact layers next the skin, out of which any antiseptic with which they may have been infiltrated may have been lost or neutralized, permitting germ-bearing air to insinuate itself under the dressing. A sparingly soluble powder, applied in such quantity as to be more than enough to absorb the exudates which escape from wounds, meets the desideratum. Many agents have been on trial, and, so far, that which has given the greatest satisfaction is powdered boric acid. The under crust, combined with blood or pus, is antiseptic and only sparingly soluble. These conditions prevent in greatest degree the exudates from decomposition.

The smarting effect of boric acid, when applied to a clean granulating surface, disappears after its combination with the exudates from the parts. If, however, the surface is free from sinuses or hiding-places, there is no advantage in washing off the covering of the granulations, and the only excuse for redressing is the curiosity to inspect the wound.

Narrow strips of aseptic gauze or lint, spread with any aseptic oleaginous covering, may protect these delicate surfaces. These applications having openings, there is ready absorption of exudates which appear in much quantity. The oil of cacia supplies to the antiseptic element of the dressing the quality of diffusibility.

Dr. G. V. Black has worked out the antiseptic qualities of oil of cacia, and has found that cinnamon-water arrests putrefaction in a culture medium when added to it as one to four. The diffusibility by which it readily combines with all parts of the culture liquid gives it a great practical advantage over many other antiseptics of greater power when thoroughly combined. The advantage of this quality for a wound dressing will be readily appreciated.

The oil of cacia has also another quality, that of preserving solids, acting like creosote in preserving meat against putrefactive invasions. When septic changes are already present in deep wounds, like the sinuses about large joints, boric acid is not the most efficient agent for destroying infection. Sublimate solution $\frac{1}{1000}$ to $\frac{1}{10000}$, cinnamon-water, and peroxide of hydrogen hold the first rank in such conditions. They make the best means for destroying putrefaction in its hiding-places. While sublimate may be the most active antiseptic as to immediate action, its ready decomposition and its want of diffusibility impair its reliability.—*Am. Pract. and News*, March 30, 1889.

Taylor (H. M.) on Delirium Following Simple Fracture of the Leg.—Both bones were broken, but the fracture was not compound or comminuted; nor was the traumatism or shock at all great. The fragments were easily put in good position, and a pillow and side splints held

them so; and, for the first twelve hours, with the aid of quarter-grain of morphine, the man rested very comfortably. In about twelve hours more, as he was suffering some pain, another quarter of a grain of morphine was given. Soon after taking the morphia, he began to sleep most of the time, but would wake up at intervals, when he seemed perfectly rational, and only showed a disinclination to remain awake, to talk, or to be in any way disturbed. In twelve hours more he became very irritable, restless, sleepless, and began incoherent talking. If spoken to sharply, he would collect himself, reply in monosylables, but in an angry, fretted voice. No amount of scolding or coaxing served to keep him still. He tumbled all over the bed, and his broken leg had to be shifted every few minutes. Bromidia, bromides, and sulfonal had very little effect upon him. Sulfonal, in twenty-grain doses, probably had the most decided quieting effect—at times secured sleep for several hours. From each of these periods of rest it was hoped he would wake up rational, but in spite of this respite to his nervous system, his condition continued for days unchanged. His temperature was at no time more than 101° F., and usually it was not higher than 100°. His pulse, however, remained as rapid as 120 or 130; but, beyond its rapidity, there was nothing unusual about it. No urinary examination could be made, as he passed his water in bed involuntarily.

There could have been no injury to any other part of the body, as the piece of iron was not large and did not knock him down when it struck his leg. The trouble about his bladder seemed to be a want of consciousness of desire to pass his water; or, rather, an inability to express his wants to others. Before the trouble with his nervous system began, his bladder had performed its functions perfectly well, and at intervals there was satisfactory action of his bowels.

For ten days the patient remained in this curious condition, and in spite of careful study of his case, it was impossible to comprehend the cause of the singular phenomenon. The possibility of fatty or other emboli was considered, the many phases of hysterical manifestations were likewise borne in mind, and also the effect of traumatism upon an impressible nervous system, such as the patient was known to possess.

The author had met with no similar condition. It was a new field for observation, and his interest was deepened, as the friends of the patient attributed his condition to the effects of the morphia, although no such idiosyncrasy was known to exist in the patient. Dr. Taylor had seen temporary mental excitement and aberration result from morphia, but usually in a few hours, at most, it had passed off. The existence of such a condition as he had described, for ten days, excluded any theory in this case that connected the condition with the taking of morphia.—*Virg. Med. Mo.*, April, 1889.

Fullerton (O. G.) on Conservatism in Minor Surgery with Special Reference to Injuries of the Fingers.—For lack of a similar and more perfect splint in the market, I have been using for some time, in this particular class of injuries, a splint and dressing which may be prepared as follows. Securing an assortment of sizes of the common paper shot-gun shells, ranging from numbers eight to twelve, inclusive:

First, remove the capped end of the shell.

Second, remove about one third of the surface of the shell by cutting from end to end in parallel lines, leaving the remainder of the shell, about two thirds of which is in the form of a trough with rounded bottom and corners. We shall then have formed a slotted flexible tube. (I also believe that a similar splint, manufactured of wood or straw pulp, saturated with an antiseptic solution—the splint being of sufficient strength and size to fit any member of the body—would commend itself to the favor of the surgeon.) Always select a size that will nicely fit the finger.

Third, take a piece of surgeon's medicated lint, of sufficient size to encompass about two thirds of the injured finger, saturate it with iodoform and glycerine, one part of the former to twenty of the latter, and place the prepared lint in the slotted tube.

Fourth, after a thorough antiseptic cleaning of the wound, if any, reducing any fractures or dislocations, and removing all hopeless fragments or spiculæ of bone, and, while extension is made by an assistant, place the finger in the slotted tube, securing it by adhesive strips passed entirely around the finger and tube, near

each extremity. Dress antiseptically, and place in a sling.

Claims for this dressing.—First, it is neat, light, cheap, and simple. Second, it is flexible, and therefore allows for extension from swelling, by simply cutting adhesive strips. Third, by cutting a fenestra opposite the wound it may be inspected and dressed daily without removing the splint, at the same time affording the proper drainage. Fourth, the splint being in the shape of a slotted tube, and when applied giving both anterior and posterior, as well as lateral, support to the injured member, thereby securely retaining the fragment in perfect apposition. Fifth, the material of which this splint is constructed being such that the surgeon can, with a knife, in a moment adjust or perfectly fit the same to the injured member.—*Medical Record*, April 6, 1889.

Perry (J. G.) on Laparotomy for the Relief of Recurring Attacks of Intestinal Obstruction Due to Peritoneal Bands and Adhesions; Recovery.—The title of this article indicates pretty well the pathological condition present which apparently had its inception in repeated attacks of peritonitis followed by dysentery. From repeated attacks of colic and fæcal accumulation above the left Poupart's ligament, the author more than suspected that adhesions of some sort existed there. An attempt was made to loosen them by manipulations in the vagina with the result of temporarily relieving the constipation. The obstruction returning, an operation was decided on and performed.

"An abdominal incision (lateral) was made, running from about an inch above and two inches from the crest of the ilium (towards the median line) down towards and within an inch of Poupart's ligament, through the parietal muscles and to the peritoneum. A small amount of fæcal matter was left as a guide at the point of obstruction, and the incision passed directly over its centre. Seizing now the peritoneum with a pair of forceps, and raising it from the intestines, I divided it the whole length of the wound. At once there was a gurgling sound, and the imprisoned mass of fæcal matter moved on quickly and disappeared. The bridle or principal adhesion had evidently been severed along with the peritoneum, but yet on the outer surface of the cæcum, which was now plainly in view, no evidences of inflammation, recent or remote, presented themselves.

"Passing now the index finger between the folds of the intestines and behind the cæcum, I found a strong band, which, as it passed behind and towards the base of the cæcum, divided, one portion running inwards, to be lost in the pelvis, the other outward and downward, losing itself in the pelvic fascia beneath the pubis. One extremity being cut between two catgut ligatures, and the other torn carefully from its adhesion, nothing now remained to prevent the whole of the cæcum from being passed in review along the palmar surface of the index finger.

"No evil symptoms occurred from this time on, while the highest point reached by the thermometer was 99⅘°.

"Three months later the patient has been heard from, and is doing well."—*Tr. Am. Med. Assn.*, March 9, 1889.

O'Callaghan on the Treatment of Tubercular Peritonitis by Abdominal Section and Flushing out without Drainage.—The case reported was that of a boy, aged fifteen, presenting the following appearance: General emaciation; pale face; bright malar flush; hurried respiration; large distended abdomen, tumid yet symmetrical; complained of dull colicky pain, never severe, but continuing day and night; appetite gone; what little fluid he could take frequently vomited. Temperature, 100°; pulse, 98, and thready. He opened the abdomen, which was full of a sero-purulent milky fluid. The peritoneum and intestines were covered with little nodules like millet-seeds, and the mesentery was like the "roe" of a fish. He flushed out the abdominal cavity with blood-warm water from the tap, "meanwhile massaging the abdomen" until the water flowed out quite clear. The boy made a perfect recovery; and was now, ten months after the operation, free from disease, and doing his daily work. As to the pathology of the disease we were more or less ignorant. As to the physiology of this method of cure we were entirely in the dark. Diagnosis was not always easy, but we should, when meeting with a doubtful case, without hesitation make an explanatory incision, as even in simple ascites or malignant disease the result was often marvellous, and the operation, with ordinary precaution, had little if any risk.—*Br. Med. Jour.*, March 16, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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SOME RECENT NOTES ON HERNIA.

McBurney (Charles) on the Radical Cure of Inguinal Hernia.— The author concisely, clearly, and completely describes the operation by the "open method," originally devised by Reisel, but independently worked out and adapted by himself, and which is as follows:

The most careful antiseptic precautions having been adopted, especially in reference to cleansing the skin of the pubic, scrotal, and inguinal regions, a free incision is made, beginning a little *outside* the situation of the internal ring, and extending a sufficient distance downward over the sac. The incision is rapidly deepened over the whole length of the canal, so as to freely expose its anterior wall —that is, the aponeurosis of the external oblique muscle. The superficial layers over the sac are now cleared away so as o plainly show the whole anterior wall of he canal; the concave border of the external ring and its two pillars are completely exposed in their whole length. The sac is still covered below the external ring by the external spermatic or intercolumnar fascia. This fascia is now opened, and, one blade of a blunt scissors being pushed under the edge of the external ring, the anterior wall is split completely up to, and a trifle beyond, the outer border of the internal ring.

The deeper coverings of the sac are now dissected off, this dissection being often best and most rapidly accomplished with the fingers. If, now, the fascia transversalis is partially removed high up in the canal, it is quite easy to separate the spermatic cord from the sac, and this, too, often in congenital hernia. If begun below the external ring this separation is often extremely difficult. The cord being now separated from a sac up to a point a little within the abdomen, the whole sac is dissected out and lifted up. At this stage, especially, the whole wound is thoroughly cleansed and the hands of the operator and assistants washed. The sac is now invariably opened, and if intestinal contents are present these are reduced; if omentum is present it is very securely tied off with catgut, a large stump to prevent slipping of the ligature is left, and the rest cut away. The stump is pushed completely back into the cavity, adhesions being broken down or ligated if any are present.

The sac is now held up vertically from the internal ring, and the operator inserts one or two fingers through the neck and a little way into the peritoneal cavity. This is done to guard positively against the return of a piece of intestine or omentum into the sac during the application of the ligature. The first assistant then places the ligature of stout catgut or prepared silk about the neck at the very highest point—that is, on a level with the general peritoneum. The ligature is gently tightened on the operator's finger, and closed very tightly as the operator's finger is withdrawn. A pedicle, sufficient in size to prevent slipping of the ligature, is left,

the rest of the sac being cut away. In congenital herniæ this step is a little more troublesome, as one must often resort to sewing the neck carefully and smoothly.

There now remains a long wound which includes the whole length of the canal, and even the entire circumference of the internal ring. The aim being to insure the formation of granulation from the very bottom of the wound to the surface, it is not sufficient to simply pack the wound. The packing could easily become displaced and the deeper layers rapidly but feebly unite. Moreover, it is desirable to bring down the stretched and laxed edge of the conjoined tendon. These stitches of stout silk or catgut are therefore placed as follows: From four to eight, according to the size of the wound, bind together the tissues which form the upper wall of the wound, that is, the conjoined tendon, the aponeurosis of the external oblique (including the inner pillar of the external ring), and the skin. The skin is carefully and deeply inverted while each stitch is tied tightly. As many more sutures bind together at the lower wall the skin and Poupart's ligament, including at the lower part the outer pillar of the external ring. This suturing positively secures patency of the wound, and the formation of granulations from the bottom.

As thus arranged the wound would be unnecessarily wide, and now two or more heavy tension sutures are carried across the wound. These also relieve the tension on the edge stitches so that these latter do not cut their way out too soon. The wound is now carefully irrigated and dusted with iodoform throughout. Lastly, iodoform gauze is firmly packed through the entire length of the canal, particular care being necessary to see that in packing at the outer angle, the whole circumference of the internal ring, including the stump of the sac, is covered by the packing.

The scrotal or labial wound is sewed up simply without packing, a drain being inserted at the lower end if necessary. This dressing is now covered with abundant masses of bichloride gauze and cotton, and the whole very firmly bound in place with bandages. Healing takes place by granulation in five or six weeks, and a firm cicatrix is left.

The patients are allowed to wear a truss after this operation. There is certainly very much to commend in it. Dr. McBurney claims for it the following advantages: 1. That it is the only method in which the sac is completely obliterated. 2. That the walls of the canal are very firmly united, throughout its whole length, by strong cicatricial tissue. 3. That, the wound being open, the risk of abscess and septic complications is reduced to a minimum. 4. That it is rapid, and applicable to every form of inguinal hernia.—*Medical Record*, March 23, 1889.

[Unanimity of opinion regarding the best method of performing a "radical cure" in herniæ cannot now be obtained. But a few years have elapsed since surgeons began to boldly and ardently advocate the obliteration of the sac in reducible herniæ. There are not a sufficient number of cases on record, and sufficient time has not yet passed, to enable even the authors of the various procedures to say what are really cures and what but temporary successes.—C. A. P.]

McCosh (A. J.) on Resection of Gangrenous Intestine Occurring in Strangulated Hernia.—This is by far the most valuable contribution to the literature of this procedure which has of late appeared.

After thoroughly exhausting the literature of the subject the author describes at length a successful case[1] of his own, in which he resected four inches of gangrenous gut in a woman of sixty-six years. The cut intestinal ends were united by two rows of silk sutures, the inner bringing together the mucous coats, the outer approximating the peritoneal surfaces (Czerney-Lembert). The gut was replaced in the abdomen, the sac extirpated, the wound sewed up, and the patient was well at the end of the third week.

Regarding the choice of operation in similar cases, the author thinks unquestionably that the most potent factor in the decision ought to be the condition of the patient. In many cases there can be no choice. To prevent death from collapse, the operation must be completed in as rapid a manner as possible, and this is best accomplished by the mere fixation of the gut in the wound. Whether or not at this time an incision is made in order to allow

[1] A similar case was recently reported to the Academy of Medicine by Dr. R. H. M. Dawbarn, of this city. He resected thirteen inches of small intestine from a woman of fifty-eight years. The woman promptly and completely recovered.

the intestinal contents to escape is a matter of little moment, as, if the opening is not made by the surgeon, the same result will be accomplished by sloughing and perforation in a few hours. This, however, is a debatable question, as is also that of the propriety of dividing the stricture at the neck of the sac. There are other cases, however, where the condition of the patient before operation is not so desperate, which open the question whether it would not be better for the surgeon to remove the sphacelated portion of intestine and, by fastening the open ends in the wound, form an artificial anus. It is, however, in the treatment of yet another class of cases that there is most uncertainty and disagreement as to the best plan to adopt. It is when the patient's condition is sufficiently good to promise the probability of his being able to undergo a somewhat prolonged operation that the advisability of performing resection with immediate suture of the divided ends demands consideration. There can be no question but that this is the ideal operation, bringing about, as it does, an immediate closure of the intestinal canal and avoiding the long-continued and dangerous treatment which the existence of a false opening generally demands. More than this, if the radical cure of the hernia be at the same time accomplished, as should certainly be attempted, the patient is saved from any further discomfort and danger from this source.

The author thinks that this operation might be more frequently resorted to than is now customary, yet does not believe that it is the wisest procedure to adopt in the majority of patients, because so often their condition has been allowed to become so desperate before a herniotomy is done that they are unable to endure the somewhat severe shock which inevitably accompanies this plan of treatment.—*N. Y. Med. Jour.*, March 16, 1889.

Park (Roswell) on the Radical Cure of Hernia.—The author favors Czerney's method of ligating the sac as high up as possible, exsecting the part below the ligature in all cases except congenital herniæ. In these the lower portion is left and closed by suture or ligature, so as to form a tunica vaginalis for the testicle, the part between the ligature being removed. Beginning from below, the pillars of the ring are brought together with wire sutures, leaving a small opening at the bottom for the cord. The incision should be long enough, great care being taken to separate the sac from the cord. Intestines are replaced in the abdomen, and the sac ligated as high up as possible. The silver sutures are twisted, the cut end being turned in and left in place. Femoral and umbilical herniæ are to be similarly treated, extirpation of the sac being essential. The author has operated in forty cases, uncomplicated by strangulation or otherwise, with universal success. The patients were of all ages, from five years to sixty. Six of the operations were for umbilical, and eight for femoral hernia. Adherent pieces of omentum are to be loosened and appendices of the same are to be securely ligated and cut off, especially if they cannot be easily replaced into the abdomen. Dr. Park takes the position that hernia, with its attendant liability to strangulation, is more dangerous to life than the operation for its cure, and therefore, recommends it in all cases.—*Buffalo Med. and Surg. Jour.*, Feb., 1889.

Wright (G. A.) on a Case of Inguinal Hernia Reduced en Bloc; Strangulation and Gangrene of Bowel.—"On November 16, 1888, I saw a man aged fifty, who had suffered from a right inguinal hernia for years. He had always worn a truss. On the 11th the rupture came down in greater volume than usual, and he used some considerable force in attempting to reduce it. The swelling disappeared, but the supposed reduction was followed by great abdominal pain, vomiting and collapse. The symptoms continued till the 13th; the vomiting at first gastric, soon became bilious and later fæcal. On the 14th the general condition had improved, the pulse was better, and his face was less pinched, but the absolute constipation and the vomiting persisted. He was in this condition when I first saw him on the 16th. The expression was moderately anxious; the pulse fair in volume, but very rapid; the tongue nearly clean, and not dry. The vomit consisted of brown fluid with a mixed fæcal and gangrenous odor. The abdomen was moderately distended, and there was no obvious hernia. *The right testis was distinctly retracted.* On passing a finger into the ring on each side, an impulse could be felt on the patient coughing. The pain was mainly just below the umbilicus, but the most tender spot was the right supra-inguinal

region. Above the site of the right internal abdominal ring was a well-defined area in which a "boggy" feeling as of the admixture of air and fluid together could be felt. Our diagnosis, of course, was: Inguinal hernia reduced *en masse;* gangrene of bowel. I cut down on the boggy area, making my incision run down to and lay open the inguinal canal. On opening the sac, black gangrenous bowel was exposed, and, on incising this, about a pint and a half of offensive, altered blood escaped. I passed my finger into the bowel, and found that the rupture consisted of a piece of intestine about four inches long. This I laid freely open, and passed my finger through the constriction at each end as far as I could. The wound was left quite open. The man seemed better at first, but died three days later, no motion having come away. No post-mortem examination was allowed, but the case was I think, undoubtedly a clear instance of reduction *en masse* without rupture of the sac."—*Lancet*, March 30, 1889.

[As the author says, this case lacks confirmation. As a contribution to the study of an obscure condition, it is, however, of interest.—C. A. P.]

Cushing (Hayward W.) on an Improved Method for the Radical Cure of Femoral Hernia.—The patient was a boy, æt. twelve years, and the hernia was of four years' duration. Operation May 14, 1888. A straight incision from Poupart's ligament over the crural ring to just below the saphenous opening, dividing the superficial structures, exposed the sac, which was found to contain omentum. The sac was adherent to the upper part of the saphenous opening. The incision was prolonged parallel to and a half inch above Poupart's ligament, and by dissection the sac was exposed and could be freed until it became perfectly reducible. It was opened and the omental mass was ligated and cut away. A continuous suture closed the sac, which was folded on itself and fixed within the abdomen à la Macewen. The crural ring was next closed by suturing Poupart's ligament with a quilted suture to the pubic portion of the fascia lata and the fascia covering the pectineus muscle, the femoral vein being protected with a retractor. When secured, the opening apparently became inpervious, the folded sac forming a pad, which was firmly fixed against the internal opening of the crural canal, while the suture tightly closed the external aperture. The pubic and iliac portions of the fascia lata, forming the margins of the saphenous opening, were next sutured in a manner similar to that by which Macewen causes the external pillar to overlap the conjoined tendon in the inguinal operation. Operation wound closed; no drainage; aseptic dressings.

The patient remained in bed two weeks, and on the twentieth day after the operation the wound was dressed for the first time. A narrow red line alone marked the seat of the operation, and the dressing was dry. An indurated mass could be felt just above Poupart's ligament, at the point where the sac had been secured. No tenderness. For the next four or five weeks a pad and bandage was worn, but its value is doubtful. This method combines the advantages of Macewen's pad with the additional security of an effective closure of the superficial structures.—*Jour. Am. Med. Assn.*, Jan. 19, 1889.

Perro (G. S.) on a Means for the Reduction of Hernia.—In the *Medicinskoje Oborzenje*, 1887, *No.* 15, the author directs as follows: After raising the pelvis upon a pillow, the thighs are flexed and abducted. The scrotum and hernia are seized with the left hand, elevated toward the abdominal walls and pressure made upon them. At the same time the index finger of the right hand is passed into the inguinal canal, and by a boring and rotating motion pressure is directed toward the horizontal portion of the os pubis. After a time the strangulated portion returns into the abdominal cavity, whereupon the other portions follow. He cites six cases in which he succeeded in reducing strangulated inguinal hernia, in which failure had followed taxis by the ordinary method.—*Annals of Surgery*, March, 1889.

Lutz (F. J.) on Fatty Tumor Complicating Femoral Hernia.—The patient, a woman of forty years, had suffered for eight years with a femoral hernia for which she had worn a truss. It had, however, come down and become strangulated twenty-four hours before she was seen by Dr. Lutz.

In performing a radical cure for the relief of this, he encountered a fatty tumor which had a circumference of three inches and which was attached to the hernial sac, about half an inch from its mouth, by a very slender pedicle. The pedicle was tied

and the tumor cut off. Microscopic examination proved it to be a lipoma.—*St. Louis Med. and Surg. Jour.*, Feb., 1889.

CHARLES A. POWERS, M.D.

THERAPEUTICS.

Garrod (A. B.) on Some Chronic Diseases of the Alimentary Canal and Liver, also of the Skin and Articulations and Their Treatment by the Long-Continued Exhibition of Small Doses of Sulphur.—The results contained in the present communication were derived from the administration of very small doses of sulphur continued for a lengthened period of time: the doses being much smaller than those hitherto employed, often not exceeding five grains each day; and the time of exhibition much longer—namely, weeks, months, and, in some cases, years. A lozenge, named the Compound Sulphur Lozenge, containing five grains of sulphur and one of cream of tartar, was usually prescribed, as being very convenient and by no means unpleasant in taste; and it was found that patients could be readily induced to persevere in using them for an almost indefinite time. The physiological effects of these minute doses of sulphur are observed upon the alimentary canal and the organs connected with it, also on the pulmonary mucous membrane and the skin. Sulphur is not an element foreign to the system, as it is contained in the most important proximate principles of the blood and flesh, and likewise of the bile and saliva. Sulphur given in the manner above described is of great value in many morbid states of the alimentary canal and liver, as in cases of hepatic sluggishness and in piles and hemorrhoidal hemorrhage; besides which the continued use of the lozenges is often quite effectual in obviating habitual constipation without producing the unpleasant action often pertaining to ordinary aperient medicine. This beneficial effect on the bowels has doubtless been the chief cause of the lozenge having become so much liked, so continuously persevered in, and so extensively used. Sulphur in small doses is sometimes useful in affections of the pulmonary mucous membranes. Sulphur has long had a reputation, and doubtless is of much value, in many diseases of the skin and its appendages. Some arthritic diseases, especially chronic forms of rheumatoid arthritis and gout, and also many cases of muscular rheumatism, are much benefited by the continued use of small doses of sulphur.—*Lancet*, April 6, 1889.

Kiernan (J. G.) on Phenacetin.—I have tried phenacetin (para-acet-phenetidin) in ten cases of migraine. Of these, three were epileptiform, arising from coarse brain disease (tumors, cerebral abscesses, etc.). Here the drug, given in five-grain doses four times daily, had excellent effects as regards the pain. The migraine was, however, replaced by fits of temper (the patients were children).

In the other cases there were temporarily beneficial effects. In two of these cases (the patients had a heurotic ancestry) a scarlatinaform rash made its appearance, twice on the use of five-grain doses. It desquamated rapidly, and was noticed only after the first two doses. In trifacial neuralgia phenacetin was often of value, when supplemented by constitutional treatment, where diathetic conditions were present. Constitutional treatment without the phenacetin did not give good results.

In a few cases of insomnia, resulting from simple exhaustion, phenacetin in ten-grain doses proved to be a valuable hypnotic. It failed in the excited states of mania and melancholia. In a few cases of agitated dementia, there was a temporarily beneficial hypnotic effect. The fulgurant pains of locomotor ataxia were temporarily relieved. In two cases of fever, cyanosis and excessive sweating were observed to result from five-grain doses.

In my judgment the scarlatinaform rash, cyanosis and excessive sweating must result in predisposed cases from any hypnotic or antipyretic which exercises its action through the nervous system. To be efficient, drugs must exercise powerful action on certain centres, and in defective nervous systems these drugs must produce effects which take the line of the least resistance.—*Med. Standard*, April 1889.

Rusby (H. H.) on Adhatoda Vasica.—This drug seems to me to be exceptionally worthy of investigation as to its power to destroy bacteria in the human system. From what is already known concerning it, it would appear to be perfectly harmless as applied to the higher orders of life, both animal and vegetable, but to increase in toxic power as applied to organisms successively lower in development.

Thus, it has been found harmless to the dog in 15-gramme doses, but fatal to flies, fleas, mosquitoes, leeches, the pupæ of aquatic insects, and even to frogs. In the vegetable kingdom it is harmless as applied to the higher orders, but immediately fatal to various classes of submerged and floating aquatics, to mould, etc. Theoretical considerations certainly possess some degree of value, and in this case they point very strongly towards the probable value of this drug in sporadic diseases. I shall be greatly pleased to hear reports of its action in diphtheria. The most promising method of application would seem to be in connection with, or following the application of pepsin to the membranes, supplemented by its internal administration.—*Therap. Gaz.*, April 15, 1889.

Caldwell (W. C.) on Chemical and Clinical Experimental Researches on the Salicylate of Mercury.—The author concludes that:

The salicylate is likely not absorbed from an acid membrane and will usually produce less derangement of the stomach than the bichloride.

The mercury is combined with an organic radical and will produce less irritation during both first- and elimination-contact actions than the bichloride.

The salicylate contains less mercury and acts slower than the bichloride, and hence has less action on albumen and on bacteria of putrefaction and far less on digestion.

The salicylate passes through the stomach to the duodenum and there is dissolved, hence it appears that exhibited with hydrochloric acid it would be better adapted for an intestinal antiseptic than the bichloride, which probably is dependent mainly on its elimination-contact action in the intestinal canal.

The mercury being combined with an organic radical, it should not be prescribed with mineral salts of the heavy metals.

Iodide of potassium given with it converts it into the biniodide, hence the salicylate should not be exhibited at the same time, unless it be in small doses.

It is insoluble in acids and should not be prescribed with drugs requiring an acid menstruum for solution.

Chemical change occurs when it is combined with muriate of cocaine, for that reason they should not be given together.

The bichloride is probably more active and effective in syphilis and probably is the best when it agrees.

The bichloride has such marked elimination-contact action, it is the better when such action is desired, as in acute tonsillitis, parotitis, etc.—*Therap. Gazette*, April 15, 1889.

New Cocaines.—The endless activity of synthetical chemistry has lately been markedly demonstrated in connection with cocaine. It is not so long since cocaine became of such great surgical importance, in spite of the difficulty of separating it from the leaves, and already it has been prepared artificially from benzoyl-ecgonine by introducing the methyl group into it. Recently, Einhorn has announced and described three further substitution compounds in which the place of methyl is taken by other groups. One of these is the lower homologue of true cocaine, while the others are metameric or higher homologues. Two of these could not be obtained in a crystalline form, but only in the form of oil. The third, however, and the salts of all three, are crystallizable. So far, it has not been stated whether any of these new "cocaines" possess any special therapeutic properties. Judging from experience with other artificial drugs, it seems probable that they may in course of time be substituted for the true vegetable alkaloid, but that, until they can be prepared absolutely free from impurities, we shall be likely to hear further of untoward results from the use of cocaine. On the other hand, the importance of this discovery can scarcely be overestimated, if it can be worked with sufficient precision to provide for an increased supply of cocaine of certain composition and good quality. Any increase in the quantity of cocaine in the market will reduce the price and favor its more extensive employment. It remains to be seen whether the new cocaines possess similar therapeutic properties, and whether they can be prepared artificially more economically than the natural alkaloid, or will exist only as chemical curiosities.—*Lancet*, April 1, 1889.

Lovett (R. W.) on Salicylic Acid in Chronic Tuberculous Joint Disease.—Most of the cases reported in this article were suffering from a joint affection clearly tubercular in type, nor was the drug given under the impression that a mistake in diagnosis had been made and that the affection was really rheumatic.

The facts are these: in chronic tuberculous disease there is no more common or distressing complication than that acutely sensitive condition which comes on sometimes of itself, and sometimes as a result of inefficient treatment. Mechanical treatment will sometimes control it and at other times is powerless to relieve it in any way. At such times the experimentation above related has shown that salicylic acid is a powerful agent in relieving the spasmodic pain if given in large enough doses, but this analgesic action is not permanent, but transitory, and passes off. It may be that salicylic acid has some power of controlling spasmodic pain in general, or it may be only that it possesses some peculiar influence over joint pain.

In the cases coming under the writer's observation, no mishaps have occurred in the use of the drug, although in cases where it was continued for a long time, the kidneys were watched to see that no nephritis was set up, and in hospital outpatients the drug has not been ordered in cases where the parents were not careful people, and able to bring the child each week to the clinic. The form prescribed has been the salicylate of soda made up in the ordinary five-grain tablets, and these have been taken readily, without complaint. The experience in the use of the drug in this connection has led of late to its wider and earlier use in the hospital clinic, *always, however, as an adjunct to proper mechanical treatment.*

The conclusions which the writer would offer, as exemplified in the cases already related, are:

That salicylic acid in large doses is useful as an aid to the mechanical treatment of chronic tuberculous joint disease, not in routine conditions, but—

(1) When night-cries are present.

(2) When the diseased joint is very painful and sensitive to jar.

(3) When vomiting and general discomfort are associated with an increase in the local disease.

That relief from pain, and diminished sensitiveness follow at once, as quickly as in acute articular rheumatism, and that the drug should be given in as large doses as for that affection until the pain is relieved or the physiological effect is produced.—*Boston Med. and Surg. Jour.*, April 11, 1889.

Newth (A. H.) on Acetanilide (Antifebrin) as an External Application.—I have not noticed any reference to antifebrin as a local sedative or antipyretic, and am unaware of its having been used as such. It occurred to me to try the effects of it in this way, and the remarkable results in the few cases in which I have prescribed it lead me to anticipate that a more extended use of this remedy as an external application will be found of great value. Country practice, especially such a healthy district as this is, does not afford much scope for experience in skin diseases, and I have only tried it for a few months. My usual plan is to prescribe it with lanoline or vaseline in the proportion of twenty grains to the ounce, combined with other ingredients that seem applicable to special cases. In obstinate irritable ulcers it soothes the pain and subdues the inflammation. In psoriasis, combined with some mercurial preparation, it acts like a charm. I have also tried it in erythema, erysipelas, eczema, herpes, urticaria, and other complaints associated with considerable irritation, and have found it a most useful adjunct to suitable remedies.—*Lancet*, April 6, 1889.

MEDICINE AND PATHOLOGY.

Crookshank (Edgar) on the So-called Hendon-Cow Disease and its Relation to Scarlet-Fever in Man.—During an epidemic of scarlet-fever at South Marylebone, and in a certain district in London, it was discovered that the milk supply of those districts came from "Hendon Farm," where the cattle were suffering from a certain eruptive disease of the teats and udders, which had a sort of resemblance to "foot-and-mouth disease." This disorder among the cattle led to a sudy of its nature, both clinically and bacteriologically, with the object of seeing if an identical germ could be discovered. Professor Crookshank isolated a streptococcus from the ulcers of the teats, and found from its microscopical appearance, its characters on cultivation, and its effects on animals, that this organism was identical in every respect with the streptococcus found in acute abscess, and named *streptococcus pyogenes* by Rosenbach. For some time Prof. Crookshank has had his attention called to the probable identity of the organisms described in puerperal fever, measles, scarlatina, and diphtheria, with the chain-forming micro-

coccus in pus. Different effects produced by one and the same species of pathogenic organisms are familiar facts. The pathogenic effect, it appears, depends upon several conditions, such as the source of the micro-organisms, the dose, the mode and place of injection, and the nature of the inoculated soil. The author then proceeds to enumerate the various diseases and conditions in which the Continental authorities principally have arrived at the conclusion, that we have to do with one and the same micro-organism.

The distribution of *streptococcus pyogenes* the writer shows to be very extensive, but he regards it as a secondary result in the acute exanthemata, and associated with septic or pyæmic complication. What the primary organism is, he is not prepared to say. But he considers Klein's *streptococcus scarlatinæ* as no other than the *pyogenes*. Prof. Crookshank, while very doubtful of the identity of the cow disease and scarlatina, still considers their coincidence significant.—*London Lancet*, Jan. 31, 1888.

Stickler (J. W.) on the Prophylactic Relation of the Foot-and-Mouth Disease to Human Scarlatina.—The author considers first the foot-and-mouth disease as it affects man. The disease is contracted either by drinking milk obtained from cows affected by the disease, or by introduction of the virus through the broken cuticle. The systemic disturbance is slight. The local lesion generally consists of an inflammatory sore-throat, with or without the development of small vesicles upon the inner surface of the cheeks, lips, and tongue. The cervical lymphatic glands are generally enlarged and tender. The tongue sometimes becomes swollen to a considerable degree. In some instances there has been an eruption of vesicles upon the feet and hands, in others a scarlet eruption has made its appearance upon different parts of the body. A number of cases, both in this country and in Great Britain, have been reported with these typical symptoms. But the epidemic of "sore throat," which occurred in Dover, England, in 1884, afforded a considerable opportunity to study the "foot-and-mouth disease" as it occurs in men. There were over 200 persons attacked, and attention was soon drawn to the fact that the course of the epidemic corresponded most intimately with the route of a particular milkman. Investigation showed that this dairyman obtained his milk from a farm where the cows were affected with the foot-and-mouth disease. Dr. Stickler, after study of the reports of this epidemic, and thinking it manifested a certain resemblance to scarlet-fever, wrote to the medical officer of health of East Kent, England, asking him to ascertain whether the persons who had suffered from the "sore throat" in 1884, had had scarlet-fever before or since. The report was returned that the members of certain households who had had scarlet-fever, had escaped the sore throat, and that persons who had suffered in the epidemic had not had scarlet-fever since. From these facts the possibility of the mutual protection of the two diseases was inferred; and believing that there was in the evidence furnished by the "Dover epidemic" an indication of what possibly might be accomplished by the use of the virus of "foot-and-mouth disease" as a preventive of human scarlatina, the author made further experimental investigation. With some virus (contents of vesicles) taken from cows having a mild form of foot-and-mouth disease, three children were inoculated, and subsequently exposed to scarlet-fever contagium. In the three cases scarlatina was not subsequently developed. It has been stated that "in animals which have once acquired the disease the susceptibility ceases for a time, or at least becomes very slight, and that animals are rarely attacked repeatedly." That the susceptibility ceases for a time has been demonstrated by Dr. Klein of London (*Lancet*, Dec. 17, 1887). He inoculated five sheep with active cultivations of the micrococcus, and subsequent feeding of these same animals with the active micrococcus had no result. The identity of the "foot-and-mouth disease" and the "Hendon-cow disease" has not been established, but there is great similarity in many of their clinical features. In 1883 Dr. Stickler inoculated twelve persons with virus obtained from horses supposed to have scarlatina. Since then not one of the number has had scarlet-fever. In the summer of the same year the author inoculated thirteen children, all of whom had been, and were at the time of inoculation, exposed to the influence of scarlatina. Of this number five escaped, but the remaining eight developed scarlatina very soon after inoculation, in one case within

five hours. None of the cases were severe. During the last year the author has inoculated two children with the contents of a vesicle produced in the abdomen of a calf by inoculation with virus derived from a patient who had scarlet-fever. With scarlatinal virus modified by transmission to the cow, two other children were inoculated. These four children had a local lesion, but only a very slight systemic disturbance. The author concludes with a hope that the profession will be incited to prosecute further this very interesting and important line of investigation.

In the discussion which followed Dr. Stickler's paper, and in which many eminent physicians participated, Professor Law expressed the most scepticism as to the prophylactic influences against scarlet-fever of the foot-and-mouth disease. Epizoötic foot-and-mouth disease has been frequently prevalent among the cattle and people of Great Britain, and yet scarlet-fever has prevailed and has been more fatal in Great Britain than in America, where foot-and-mouth disease is almost unknown. Since 90,000 persons had died of scarlet-fever in Great Britain in five years, the speaker thought that did not argue very forcibly for prophylaxis. As to experimentation with the foot-and-mouth disease, Professor Law thought that it should be done on the other side of the Atlantic, where no danger to the fifteen million dollars' worth of cattle in the United States might result.—*N. Y. Med. Red.*, Dec. 10, 1887.

E. S. B.

On the Curability of Syphilis.—The question of the curability of syphilis hinges largely upon the fact of the possibility of a second infection.

G. Harrison-Younge in this connection reports[1] the following interesting case:

Private G. W. contracted primary syphilis in March, 1882. In September, 1883, he was admitted into the station hospital, Bangalore, with secondary syphilis. At this time there was a well-marked rash on the body and legs. Under treatment by alteratives he recovered and was discharged to duty. During June, July, August, and September, 1884, he was again under treatment, and during this time suffered from disease of the nasal bones, condylomata, nodes on the tibiæ, and ulcers on both legs. He was treated with mercury, iodide of potassium, and tincture of iodine at different times. On September 12, 1884, he passed an invaliding board, and was sent to a hill station for change. During 1885 he had four admissions for secondary syphilis, spending a total of one hundred and thirty-six days in hospital. Since 1885 he has been free from syphilitic manifestations, but there still remain well-marked syphilitic scars over both tibiæ. In January, 1889, he again contracted primary syphilis, and was admitted into hospital with a typical Hunterian chancre. This has been followed by induration of the glands in the groin, a roseolar rash, and ulceration of the throat. Since his present admission he has been treated with perchloride of mercury and iodide of potassium, and under this treatment the symptoms are rapidly disappearing.

Two similar cases are reported[2] by John St. S. Wilders:

A., twenty-two years of age, a strong, healthy man, contracted a hard sore in 1874, which was followed by severe secondary symptoms, for which he was treated for more than three years and a half. He was most anxious about himself, and carried out all my directions with most scrupulous fidelity. At the end of this period he was and remained absolutely free from any symptoms whatever; this I was able to verify, as I saw him very frequent. In 1884 he again came under my care with a well-marked indurated chancre, which was followed by secondary symptoms which ran the usual course: they were, however, of a very mild character.

B., aged thirty, contracted a hard sore in 1873; the secondary symptoms were very severe, the throat and tongue being the points most seriously affected. He remained under treatment for four years, after which he had no further trouble. In 1886 I received a letter from him, telling me that he had contracted a sore, which a hospital surgeon had pronounced an indurated chancre. I saw him within a few days, and found such to be the case without a shadow of doubt. This sore was followed by secondary symptoms in their usual sequence, which, as in the preceding case, were of a mild character. In both of these cases I have not the slightest doubt that reinfection occurred, as I made the most careful examination and investigation.

[1] *Brit. Med. Jour.*, March 16, 1889.

[2] *Brit. Med. Jour.*, March 23, 1889.

Very naturally the discussion of this subject has brought in question the proper treatment of the ailment.

In the *Lancet* for March 23, 1889, Henry Lee gives the following as what he considers the proper treatment:

Briefly, then, the patient should be under a mild and sustained course of mercury of from eight to twelve weeks' duration. During this time the patient's gums should be kept slightly tender; not that there is any virtue in the gums being affected beyond the evidence that it affords of the action of the medicine. In order that this action may not be interfered with, it is essential that the patient should not be exposed to cold air or cold water. Small doses of the iodide of potassium may be given to assist the action of the mercury. The necessary action cannot be maintained by mercury given internally. If continued for sufficient time and in sufficient doses it is sure to disorder the bowels, and it then has to be discontinued. When once the action of the mercury has subsided it is very difficult to renew it. A patient's system is in some sense proof against it, and there is no way of properly completing the course. All that can be done by mercury can be done by the calomel bath, which, on account of its cleanliness, is preferable to the inunction of mercury. Its action on the skin tends to develop the disease there, and it prevents salivation. It leaves the bowels unaffected, and may be continued any necessary length of time. After some experience, I deliberately assert that I cannot recall a single instance in which this treatment was in the first instance carried out where the bones or the nervous system were subsequently affected. It occurs to me constantly to see old patients who ten, fifteen, or twenty years ago were treated, and who say that neither they, their wives, nor their children have ever had any symptoms of their former disease. These cases afford as good evidence of "a cure" as can be found in the whole range of medical literature.

Another very serious question here presents itself—namely, whether the frequent or continued administration of iodine may not do positive harm. Sir B. Brodie informed me many years ago that in his opinion a prolonged course of the iodide of potassium produced a more permanent depressing effect upon a patient's constitution than a corresponding course of mercury. This opinion I can fully endorse; but independently of the general nervous debility caused by the prolonged use of the iodide of potassium, the actual suffering produced by anxiety of mind incident to a course of treatment extending over years is often far greater than would result from the disease if allowed to run its natural course. Sir B. Brodie has left on record some particulars of four cases in which the minds of patients became seriously disordered in consequence of the long-continued treatment by iodine.

Dyson (W. W.) on Vaccination as a Cure for Otorrhœa.—Vaccination has played such an important part in preventive medicine that it stands preëminently at the head of prophylactics; its virtue in relieving humanity from one of the most virulent scourges of modern times, gives it this distinction, and, as the doctrine of substitution of disease is the basis of its action, we find its utility in counteracting other diseased states equally potent. Its use in whooping-cough has been demonstrated to be of benefit beyond cavil, and while we have not had sufficient opportunity to investigate its applicability in treating otorrhœa so fully as to place its curative virtue beyond dispute, yet we have every reason to believe that its intelligent application in this troublesome affection will not disappoint the confidence we feel disposed to place in it. The little success that even our most approved plans of treatment crown our efforts with in managing this trouble renders any measure which holds out a possible chance for efficiency very acceptable to the medical profession.

The case in which its usefulness was first demonstrated was that of a gentleman who in childhood had a severe attack of scarlatina with otorrhœa as its sequel; the latter had existed over twenty-five years. The right ear only was affected and hearing had been almost entirely destroyed. Remembering the anatomical distribution of the nerves and their crossing from right to left, and *vice versa*, we thought that by establishing an issue on the opposite side of the body we might draw the irritation from the diseased ear to the arm, and thus give the affected part a chance to heal or resume its normal condition.

With this in view, we therefore vaccinated the patient on the left arm with bovine virus, and, we are gratified to add, with the most satisfactory results.

At the seventh day, when suppuration in the vesicle had been established, the discharge from the ear began to diminish, and in a few days had entirely disappeared, and at this writing, some five years after, there has been no return of the trouble. While we are not disposed to think that in every case this treatment would be available, yet it is certainly worth trying, as any measure offering any inducement for success in this unpleasant affection will gain advocates as soon as its utility will have been demonstrated.—*College and Clinical Record*, April, 1889.

SURGERY.

Lee (B.) on Hæmatoma Oris, a Sign of Spinal Injury.—A child eight months old fell four feet, striking on the head and thigh. Examination later revealed what seemed to be hip-joint trouble on the right side, which was treated by various mechanical devices for three weeks. At that time the mother noticed a slight swelling of the gum above the right central incisor in the upper jaw. This gradually increased, and as it did so, became of a livid purple color. It had no tendency to ulceration, nor did it seem painful, except at times when it would cause the child to refuse her bottle for a few hours. After a time it showed itself on the inner side of the jaw as well, and extended laterally in both directions; and bulging down over the teeth completely hid them. Occasionally there would be a slight hemorrhage from it, which was followed by a reduction in size. By the first of December, both hips had improved most encouragingly and permission was given for the child to sit up. This was followed in a few days by most serious results. The attacks of screaming were renewed, sleep was much disturbed, appetite lost, and a certain amount of febrile action set up. It was evident that the upright posture caused her great pain and it was also observed that the movement of the right arm was painful to her. A day or two later the power of motion in this arm became impaired. It was then remembered that occasionally, all along through her illness, movement of this arm had been painful.

On the eighteenth of December, a careful examination demonstrated that there was disease very high up in the cervical spine, possibly between the atlas and the skull. The shoulder soon became slightly elevated and the left arm also began to lose power. Every attempt to place her in the erect position for the purpose of adjusting mechanical support induced paroxysms, threatening convulsions, in which the face became livid and the respiration difficult. She was kept flat on the back with the head slightly lower than the shoulders, extension being made upon the occiput horizontally, sometimes including the chin. This was maintained continuously, and manifestly added much to her comfort.

Emaciation now progressed rapidly, and her face became excessively pallid and lips colorless. The tumor of the gums steadily increased and hemorrhage became more frequent. Toward the middle of January a slight purple discoloration manifested itself below the left eye; later under the right eye. A few days later the eye began to protrude, and it was evident that there was a hæmatoma of the orbit. Loss of power in the lower extremities was now very apparent. In order to employ more efficient extension a padded steel collar was now applied acting upon the occiput and chin. This was not well borne, however, and it was soon removed. Symptoms of meningeal inflammation, slight convulsive movements, alternating with stupor, and constant vomiting now supervened. As a last resort another effort was made to apply the spinal splint with an attachment for head extension. In order to do this the child was placed face downward upon the knees and kept in that position for possibly five minutes. At the end of that time it seemed as if all the blood in the brain had rushed into the face. It was streaming from the mouth. The turgescence of the gums was excessive. Both eyes were prominent, the left frightfully so. It seemed as though all inhibitory power over the circulation had ceased, and the blood flowed simply in obedience to gravity. After this time the excessive restlessness abated, and there was little suffering, but the patient steadily sank and death ensued within twenty-four hours.—*University Med. Mag.*, Feb., 1889.

Axford (W. L.) on Traumatism and Tuberculosis.—Two very pure cases which have occurred in my practice may perhaps serve to bring out the import-

ance of trivial injuries when occurring in the vicinity of a joint, as well as to show the intimate connection between traumatism and tubercle. A. H., about thirteen, was playing with some boys, when a trifling dispute arose. One of his companions kicked him with some force on the outer side of the leg, just over the outer condyle of the femur. He thought nothing of the injury, and at the end of a few days it was forgotten. I saw him a few weeks after the affair, found that he had lost much flesh, had a painful, fluctuating knee, and a large abscess over the calf of the leg. Family history of the best. A diagnosis of tubercular disease was made, and operation proposed and accepted. The joint was opened freely, a large quantity of pus evacuated, the cavity thoroughly explored, and drainage with daily washings carefully carried out. The abscess was also evacuated and drained. I could find no evidence of tubercle, and began to doubt somewhat my original diagnosis. The bones were everywhere intact. The patient began to improve at once, and at the end of three weeks was to all appearances about well. Suddenly there was a great exacerbation of symptoms and another operation became necessary. On raising a horse-shoe-shaped flap with apex below the patella, the trouble was at once seen. A large tubercular focus had formed in the outer condyle of the femur, had softened and ulcerated its way into the joint. The end of the bone was a mere shell. The subacute synovitis and cold abscess which first appeared had been simply sympathetic conditions induced by this tubercular deposit. Nothing was left to do but to amputate the leg. Totally unprepared for such an emergency, I was obliged to amputate with a scalpel and saw the femur with a finger saw. The boy made a good recovery. Had I, when first operating, taken into consideration the location of the blow, together with the sympathetic accumulations of pus in, and in the vicinity of the joint, made an exploratory puncture of the end of the femur with the drill, in all probability the focus would have been found; and by thoroughly scraping it out with the sharp spoon, I would have saved the leg. Experience teaches.

Jennie, age six or seven, an inmate of St. Joseph's Orphan Asylum, while playing with her companions, one of them seized her hand and wrenched the elbow severely. Some weeks after, the sister in charge called my attention to the fact that there was a swelling over the elbow joint, and that the joint was sore and stiff. I immediately diagnosed tubercular disease. Under an anæsthetic, a cold abscess holding a couple of ounces of pus was evacuated, and scraped. No appreciable disease of the joint. No marked fluctuation or enlargement of the ends of the bones. I did not open the joint, as I believe in a thorough trial of rest with general treatment. A plaster splint was fitted, and oil with iron given internally. At the end of seven weeks the child looked much better, but the joint was, if any thing, worse. Slight fluctuation and some pain and tenderness. An anæsthetic was given, and the opening into the abscess, which had never healed, was explored, and found to lead directly into the joint. It had discharged a thin, ichorous pus in small quantity, necessitating a change of dressing about once a week. The usual incision for resection was made, exposing, after dividing the olecranum and dislocating the arm, a case of fungoid disease of the synovial membrane, of course tubercular in character. About this time I noticed the wound suddenly grow pale, and found that my patient was apparently dead. She was immediately hung up by the heels, and artificial respiration commenced. As soon as the blood gravitated to the head she began to gasp. She was restored, and the operation, which consisted of cutting and scraping away all the synovial membrane and such of the ligaments as were softened, was completed. The cartilages were removed and the wound dressed. The patient is doing well so far, and will, I believe, recover with a good arm.

These two cases are to me very instructive. They certainly show the intimate relations between traumatism and tuberculosis, and that in a marked manner. In the first case it was the outer condyle of the femur which received the injury, the soft tissues escaping, and in this very seat of injury the tubercle forms. In the second case the bones escape injury, and then escape tuberculization. The neoplasm does not attack at random any of the tissues of the injured joint, but selects those which have been prepared by injury for its reception. — *Med. Standard*, April, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

With the active collaboration of

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OCCASIONAL REPORT ON DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

Kellogg (J. H.) on the Relation of Dress to Pelvic Disease.—The subject is considered under five heads: The comparative study of the functions of respiration in civilized and uncivilized women; of the influence of respiration upon the pelvic organs; of the influence of constriction of the waist upon intra-pelvic pressure; of the amount of external pressure exerted by a tight corset, or other form of constriction of the waist, and direct measurements of the amount of displacement of the uterus produced by constriction of the waist. These different points were studied by experimental observations, special instruments being employed to measure and record the results of the experiments. He concludes from these that: 1st. The costal respiration of civilized women is acquired and is not due to physiological causes or gestation, but only to their restricting mode of dress. 2d. The normal "respiratory" movements of the pelvic organs are lessened in extent by constriction of the waist. 3. Constriction of the waist increases intra-pelvic pressure. 4. The average pressure exerted by a tight corset or band at the waist, is, in ordinary respiration, about 0.3 inch of mercury. 5. The uterus is forced down in the pelvis from 0.2 to 0.5 inch by the application of a corset, while in normal respiration it moves up and down from 0.1 to 0.3 inch, which may be increased by straining or coughing to 0.5 inch.—*Trans. Mich. State Med. Soc.*, 1888.

White (J. W.) on Gonorrhœal Salpingitis.—The history of the case of a prostitute of the better class is reported, four men having been infected with an extremely virulent type of gonorrhœa through their relations with her, which they had enjoyed at about the same time. As the author had, at her request, examined her, and had given her a "clean bill of health" just before this time, he examined her again, finding no sign of trouble other than a clear, mucoid discharge from the cervical canal. Shortly after he found her with marked symptoms of pelvic peritonitis, and examination revealed the presence on either side of the fundus of a tender, convoluted mass extending to the pelvic wall. Treatment relieved the symptoms, but after an unpermitted return to her former mode of life, she was again affected with the same,—or of more severe in character—symptoms of pelvic inflammation. These were so urgent that oöphorectomy was performed, and tubes distended with pus were removed, the patient rapidly regaining her former health and her professional position.

This history is taken as a text for a discourse on gonorrhœal disease of the female pelvic organs as viewed by the general surgeon, and the great uncertainty of appearances as evidence in forming an opinion as to the absence of any infective disease of female genitalia. The extreme

views of the supporters of the "latent gonorrhœa" theory of Noeggerath are criticised as *post hoc, ergo propter hoc* conclusions, as too great a multitude of exceptions to the rule exist. The conclusions formed by the author during a very large experience, are that gonorrhœa in the male is distinctly a local and curable disease; that probably no influence can be exerted by a specific germ, which has lain dormant for years in the urethra, in the etiology of pelvic disease in the female; that the apparent production of such is due to the urethral discharge, caused by unhealed erosions of the mucous membrane, or by stricture, and which may be made infectious by irritation of chemical or mechanical nature; that gonorrhœal salpingitis, as a result of progressive endometritis from vaginal infection is comparatively rare, and that many cases of what are considered as such are relieved by rest, counter-irritation, etc. The specific nature of the gonococcus has not been entirely demonstrated, and, until this has been done, we should treat the question of operation with due caution.—*British Med. Jour.*, Feb. 9, 1889.

Morgan (John) on Congenital Displacement of Ovaries into the Canal of Nuck.—Two cases in the service of Mr. D. W. Giffard at the Brighton Hospital for Women and Children are reported; the first in a child of six months, who presented a hard growth of the size of a walnut in the upper part of the left labium, movable behind, but adherent to the skin in front. It was exposed by incision and found to have a pedicle occupying the canal of Nuck. This was ligated and the organ removed was found to be the ovary containing many hemorrhages into its structure. The second case was in a child of five weeks. An oval body of the size of a horse-bean was found in the upper part of the right labium, movable, but irreducible. This was accompanied three days later by a reducible hernia. The ovary was removed as in the former case, and was found on microscopic examination to be a unilocular ovarian cyst, its wall containing much newly formed fibrous tissue and spindle cells. Mr. Giffard believes that cases of this character are not as uncommon as would be thought from the small number of recorded cases, and favors early removal to prevent the probable trouble the misplaced organ would cause at or after puberty. The tendency to malignant character shown in the structure of the organ in his second case constitutes another argument in favor of early excision.—*British Med. Jour.*, Jan. 26, 1889.

Mann (M.D.) on a Case of Ovarian Pregnancy.—The specimen, not accompanied with a history of definite nature, was sent to him by Dr. Freeman of Smithport, Pa. The patient had died, after some obscure septic symptoms, no cause being apparent. At the autopsy a small cyst springing from the ovary, without a pedicle, and containing a concavo-convex placenta, the character of which was proved to be such by the microscope. No fœtus was found, but Dr. Freeman had told him that at the time of its removal the wall of the cyst was transparent and that he had distinctly seen a fœtus through it. The specimen was subsequently frozen and then boiled, having been kept afterward for some time in alcohol. The cyst had not been opened when he received it, and he accounted for the absence of the fœtus by the treatment which the cyst had received. The ovary contained no other cysts whatever.—*Med. Press*, West. N. Y., Feb., 1889.

Homans (John) on a Case of Fibroid Tumor Causing Intestinal Obstruction.—The patient had suffered from two attacks of intestinal obstruction, one having been accompanied by stercoraceous vomiting during gestation, spontaneous recovery occurring at both times. The presence of a fibroid tumor posterior to the uterus was recognized, but nothing was done on account of the pregnancy. Soon after delivery, which was normal, a third attack of obstruction ensued, finally causing the death of the patient. At the autopsy the tumor was found to be entirely separate from the uterus, and to be attached firmly to the omentum and intestines, receiving its blood supply entirely through these adhesions, which formed foramina between the viscera and the tumor through which spaces portions of the gut had passed and become constricted. The tumor weighed two pounds and a half, and was of a dumb-bell shape. The exhibitor considered the case one which presented a strong argument against the marriage of women with fibroids, and for the removal by abdominal section of subperitoneal uterine tumors.—*Boston Med. and Surg. Jour.*, Feb. 14, 1889.

Partridge (E. L.) on Induction of Labor in Kidney Disorders during Pregnancy.—The author is sceptical as to the occurrence of true convulsions in connection with parturiency without an accompanying disturbance of the renal function. The cases which seem to unsettle such a belief may be only apparent exceptions to the rule, as often the urinary signs and uræmic symptoms are of the slightest and most erratic character, and often the albuminuria may be absent on the days on which the urine is examined. As to interference with gestation in cases presenting signs of renal disturbance, no general rule can be formulated. The history of previous uræmic attacks during former pregnancies should always make the question of arresting gestation a prominent element in the problem of treatment to be solved, and this should be answered in the affirmative in case any evidence of the same complication should be observed in the case under consideration. The author holds that the danger of a chronic nephritis, induced by the repeated attacks of the functional renal disturbance, is too great to be overbalanced by the desire to save the child, or by its rights, as there is every reason to believe that spontaneous abortion and eclampsia will follow, if an expectant plan of treatment be adopted in such a case, and that both mother and child will be lost, by temporizing, after symptoms of uræmia have developed, in the larger number of cases. The histories of three cases are reported, all bearing on this point of organic renal disease resulting from successive attacks of puerperal uræmia, but only presenting symptoms during the existence of the pregnant state, two of which were fatal after premature labor had been induced, and the other one of recovery after spontaneous abortion at the beginning of the third month, although grave symptoms of uræmia, not preceded by any urinary signs, developed immediately after the miscarriage, but gradually subsided. The symptoms of uræmia developed in all immediately after delivery, and the amount of albumen found in the urine before labor was insignificant or a mere trace. His own conviction is that in every case in which chronic nephritis exists, the immediate interruption of the pregnancy is strongly indicated.

In "puerperal albuminuria," the purely functional disease, action in arresting gestation should depend on the amount of albumen excreted; its tendency to increase or diminish; the presence or absence of symptoms and the general condition of the patient. In forty per cent. of his cases of this condition he had induced labor. Vomiting, visceral disturbances, and marked decrease in the amount of urine excreted are to be regarded as grave symptoms, and demand an exercise of great vigilance and readiness for action on the part of the physician.

In the discussion following the reading of the paper, the author expressed the opinion that in the treatment of eclampsia venesection was preferable to the use of veratrum viride in the majority of cases.—*Four. Obstet.*, April, 1889.

Skene (A. C. J.) on Pelvic Cellulitis.—By this term is to be understood inflammation of the pelvic cellular tissue in the suppurative stage. The author's experience comprises some complications of this condition which are unique as far as his knowledge extends, as he has failed to find any records of similar cases. Three cases of extension of inflammation, from the broad ligament to the sheath of the psoas muscle, and burrowing of pus outward and upward, are cited, in one of which the diaphragm was perforated and the pus discharged into the bronchi. In two false anchylosis of the hip and knee joints were present. The following summary of his views is given by the author:

1. That pelvic cellulitis, uncomplicated, occurs frequently.

2. That sub-peritoneal pelvic hæmatocele should be recognized as one of the causes.

3. That aspirating may be employed before and after suppuration, with advantage in suitable cases.

4. That abscess in the cellular tissue of the pelvis should be opened from the vagina when the conditions are favorable.

5. That laparotomy is advisable when the vaginal wall is not closely adherent to the abscess sac.

6. That laparotomy should be made when a pelvic abscess opens into the bladder and suppuration continues.

7. That cellulitis may extend to the psoas muscle, and give rise to psoas abscess.—*Bklyn. Med. Four.*, Jan., 1889.

Adams (Samuel S.) on Hernia of the Pregnant Uterus.—The author has collated the histories of twenty-four

cases of this condition, comprising all those reported which he has been able to find in literature. The varieties described are: Inguinal, 10; crural, 1; umbilical, 4; sacro-sciatic, 1; and ventral, 8. The treatment must depend on the variety of the hernia and the period of gestation; premature labor to be induced in cases of the inguinal and crural forms, if the fœtus can pass the ring or the organ is reducible; otherwise Cæsarian section or Porro's operation. In cases of the ventral or the umbilical variety, delivery can usually be effected naturally, the uterus being supported, or with the forceps. Reposition should always be attempted by the employment of gentle taxis, and the organ be retained when reduced by a bandage or truss. —*Am. Jour. Obstet.*, March, 1889.

Queely (E. St. G.) on Noma of the Vulva.—A case of gangrenous inflammation of the labium majus occurring in a patient æt. nine is cited, no history bearing on the causation being obtained, except that of an attack of measles four months previous. The affected parts were dusky in color, much swollen, and ulcerated in spots. The pain was intense, and there was severe constitutional disturbance. After the eighth day the symptoms diminished in severity, and convalescence began. The author found an ointment of zinc oxide, with a little carbolic acid added, to be most beneficial in allaying irritation and promoting the healing process, than any other topical application used. Quinine, iron, and stimulants were given freely.—*Lancet*, Jan. 12, 1889.

Kelly (H. A.) on Treatment of the Stump after Abdominal Hysterectomy.—The author describes a "combined intra- and extra-peritoneal" management of the uterine stump left after removal of the abdominal part of the organ. The stump (an elastic ligature having been placed around it before the amputation) is reduced inside by a continuous buried suture of strong catgut, until the lateral margins are nearly approximated. The peritoneal surfaces at the edges of this almost occluded wound are brought together by interrupted sutures, which are tied and the ends left long. When traction is made on these to one side, a needle, armed with a stout catgut or silk ligature, is passed from before backwards deeply through the tissues of the stump below the elastic ligature, in order to control hemorrhage from the uterine artery, and tied. After the same procedure has been followed on the other side, the elastic ligature is removed, and other ligatures passed at a deeper level than the first if there be any oozing from the stump. This is now lifted up by pulling on the ends of the upper row of sutures, and the peritoneal surface covering it is stitched to that of the abdominal wall until the lower angle of the wound contains the stump projecting extra-peritoneally. The remaining part of the incision is closed in the usual manner. The ends of the sutures closing the edges of the stump are left long until all danger of secondary hemorrhage is past, and are used as tractors to bring the stump into view if this should occur. The advantages of this management of the stump are, that there is no sloughing of the same and consequently rapid healing of the wound; no possibility of hemorrhage into the peritoneal cavity, and perfect control of the stump if bleeding should occur from it, allowing of the use of hæmostatic measures without reopening the peritoneal cavity.—*Am. Jour. Obstet.*, April, 1889.

Winter (J. T.) on a Case of Absence of the Bladder.—The patient was a girl eight years of age, and was first seen six years previous. Examination showed absence of meatus urinarius, labia minora, and vestibule. The labia majora were represented by two small folds of skin, and just at the inner sides of these were the openings of the ureters, separated by about two inches. The pubis was depressed, and was soft to the feel. "Bearing-down" pains were followed by the protrusion of a small tumor from this imperfect valve. This being removed and examined microscopically, was thought to be composed of vesical epithelium. There was constant dribbling of urine.—*Am. Jour. Obstet.*, April, 1889.

Outerbridge (P. E.) on a New Instrument for the Treatment of Sterility.—The author has devised a steel-wire "dilator," which resembles in shape a skeleton bivalve speculum, at least as far as the blades are concerned, which is to be introduced into and allowed to remain in the canal of the cervix uteri for the few days preceding and those subsequent to menstruation. The instrument is to be carefully adapted in size and curvature to that of the cervical canal in each case, and must

be fitted with as much or more care even than an intravaginal pessary; it should also be heavily plated with silver. The instrument is made self-retaining by a slight eversion of each blade at its beak and by its elasticity; should be of from one to three inches in length; is easily introduced by a very ingenious instrument specially devised for the purpose, and which must be seen in order to be understood; has never, in the author's experience of four month's use, during which it was used upwards of eighty times, caused any trouble other than a discharge, due to a faulty fit of the instrument and easily remedied by changing its size or shape, and is an admirable means of maintaining a patent cervical canal in cases of obstructive dysmenorrhœa or in those demanding free drainage of the uterine cavity.

The author recommends its introduction at the eighth or fifth day prior to an expected menstrual period, and its retention for a similar length of time after; removal before that time if the period is absent, or if increased discharge or pain is present. It can be easily removed by the use of a tenaculum or blunt hook. In cases of dysmenorrhoea or of any thing but sterility, its use is to be determined by the requirements of the case. Two cases are cited as examples of an unspecified number of successful results following the use of the instrument, in one of which pregnancy occurred after seven, and in the other after eleven, years of sterility, only one introduction being necessary.

The author deprecates the unintelligent use of his instrument, and repudiates the belief, that it alone is the solution of the problem as to the cure of sterility. He only advises its rational and intelligent employment in suitable cases, in the belief that this will establish its claims for recognition as a valuable addition to the means by which sterility may be removed. — *Med. Record.* April 20, 1889.

[The careful and discriminating use of this instrument seems to be a most promising method of treatment. Having seen the instrument and heard the results following its use from its originator, the writer deems it to be eminently deserving of a fair trial. It will unquestionably be found superior in every respect to the glass plug or stem used after dilatation of the cervical canal, or to any of the ordinary devices used at present for the drainage of the uterine cavity in endometritis or after curetting, and it is difficult to understand how it can be a cause of serious trouble if properly fitted and used only in suitable cases. It is infinitely preferable to a stem, and is theoretically as safe as any of those intrauterine manipulations which are endorsed by every gynæcologist, and performed by all for diagnostic or operative purposes, where no unwarrantable use is made of it. J. S. H.]

OCCASIONAL REPORT ON DISEASES OF THE EAR AND EYE.

BY A. T. MUZZY, M.D.

Guye. Sound-Wave as a Cause of Error in Measuring the Acuteness of Hearing.—All know that the image of sound is not as easily observed as the image of the light. While images of the light are obvious, sound-images are not observed save under special conditions. This is all due simply to the enormous difference in length between a sound-wave and a light-wave. For a medium sound-wave is one hundred thousand times longer that a light-wave. For sound-waves obstacles are in general too small to project reflections or images that are distinct. Usually we only observe sound-reflections when they are projected by a great building, by the street, etc., but in our houses we do not perceive any. For some years now I have noticed that it is necessary to allow for sound-reflections when measuring the acuteness of hearing, and I have never neglected to fix the attention of my pupils on this cause of error. The watch can be used to measure the acuteness of hearing for distance of each ear separately so long as the distance does not exceed a number of centimetres—usually ten. Yet from the moment this point is exceeded it is necessary for the patient to close the other ear. If this precaution is not taken the experiment is defective, for the other ear, if it has much greater acuteness of hearing, interferes with the result. All otologists who employ the watch or an analogous apparatus—for example, Politzer's acumeter—for measuring acuteness of hearing, should strive to eliminate it in the following simple manner: M. Brunschwig published, in 1884, an observation taken by him in the clinic of M. Baratoux at Paris. The explanation of this observation seems to

have escaped both the observer and the writer of the extract. "A man 22 years of age detects the watch distinctly at a distance of 20 to 16 centimetres; he does not detect it from 16 to 13 centimetres, and from 13 to 0 centimetres he detects it again. The experiment repeated gave the same results. Later the observer was ununable even to note it either in this or other patients. This remarkable phenomenon he considers similar to ocular scotoma. This observation seems to me to be explained by sound-reflections. The patient detects the watch, it seems to me, from 0 to 13 centimetres with the observed ear, and from 16 to 20 centimetres with the other. The failure in repeating the experiment in the following examinations was due to a more favorable position probably of the unobserved ear in the first examination—that is, much nearer to a wall or piece of furniture, which was capable of reflecting a part of the sonorous vibrations and directing them to this ear, while in the later experiments a less favorable position was chosen. Since that time I have made a number of experiments which I desire to show you, not only as an explanation of the curiosity of M. Brunschwig, but because they seem to me to possess points of general interest. I have found that the obscure spot of M. Brunschwig can easily be demonstrated, not only in persons having one ear normal in hearing while the other detects a watch less than 10 cm. away, but also in those in whom both ears are normal. In these persons, when they close one ear by pressing in the tragus, they can still detect the watch for 4 or 10 cm. Then comes the obscure spot, and finally between 15 and 25 cm. the watch is heard again by the other ear. The patients generally cannot tell, at least until after experimenting frequently, with which ear they hear or whether by both simultaneously. I have found that the distance at which the good ear is placed from an armature or other piece of furniture taking the office of a reflector, has a great influence on the distance at which the watch can be detected. My experiments have been made with a watch of a feeble stroke, of tolerably high musical sound, and which is distinctly detected by normal ears, at least by those of young persons, at a distance of 30 ft. (9 metres). I call the distance when the watch is detected by the examined ear itself with occlusion of the other, whether the examined ear be open or closed, the *first zone*. Then comes the *obscure spot*, where the watch is not detected even when the other ear is open, and finally the *second zone*, a space where the watch is detected when the ear opposite to the examined one is open. The following is a table, the figures of which merit especial confidence, as the patient was a student of medicine, who, from repeated trials, could tell exactly the moment when he detected the watch and when he ceased to detect it. *Auditive acuity:* R. ear 30 ft.; Left, 5 ft. *L. ear closed by pressure of the finger.*

	R. ear, distance from armature:				
	3. M. (10 ft.)	2. M. (6½ ft.)	1. M. (3 ft.)	.50 M. (1½ ft.)	.25 M. (½ ft.)
First zone	0— .08	0— .08	0— .08	0— .08	0— .08
Obscure spot	.08— .25	.08— .25	.08— .14	.08— .14	.08— .14
Second zone	.25—2.	.25—3.	.18—4.	.14—4.50	.14—6.

Two other tables bring out the above indications still further. The second presents a spot between 0.4 centimetre and .18 centimetre when the watch was not detected by either ear alone (the right being under examination and the left towards the armature), the second zone extending from .18 centimetre out to. 50 centimetre—that is, the sonorous vibrations were too feeble to be detected by either ear alone, yet the two impressions combined did produce a distinct impression. It seems to me that this should be explained by a central accumulation of two nervous impressions, probably at the acoustic centre. Those who desire to study sound-images may find very interesting details in an article by Lord Rayleigh in the English review *Nature*, of June 28, this year ('88). I have desired simply to search for an explanation for the obscure spot, and show that it exists even in normal ears."—*Rev. Mens. Laryng. d'Otol.*, Oct., 1888, Paris.

Bacon (Gorham) on Treatment of Acute Inflammation of the Middle Ear.—Others have had the same success with the artificial leech that I have had. It consists of a scarificator composed of 7 lance-shaped needles concealed in a cylinder, and acts by the release of a spring; the depth of the punctures being regulated by screw extension of the cylinder about the needles. After scarification of the tissues, temporal or mastoid as conditions indicate a cupping-glass from ¾ to 1 inch diameter is taken from hot water and applied over the scarification to increase the flow of blood. The reasons already given a year ago for substituting this combination for the leech

(*Hirudo*) were the following. 1. The leech is particularly disagreeable to many patients, especially children. 2. It is frequently very difficult to arrest the bleeding following a leech-bite. 3. A leech-bite occasionally gives rise to erysipelatous inflammation and ulceration, and not infrequently produces a circumscribed abscess even in apparently healthy individuals. 4. Leeches are not always to be had, especially in the country, and are frequently a troublesome remedy; and also expensive. With the artificial leech the quantity of blood abstracted can be regulated, and its application is much more agreeable to the patient, and it is an instrument always at hand. It is in the first or hyperæmic stage of inflammation that local abstraction of blood is followed by such favorable results. Not only in acute inflammation of the middle ear is this procedure of great service, but also in similar inflammations of the external canal and mastoid cells.—*Med. News*, March 30, 1889.

Knott (J. F.) on Synotia; an Abstract from the Danish.—The relative frequency of this monstrosity with cyclopia is made in the following table.

	Cyclopia	Synotia	Both
Man	103	16	18
Ox	29	6	—
Sheep	48	104	44
Pig	127	12	29
Dog	27	4	27
Cat	11	1	12

There is less deficiency in synotia than in clycopia, while in cyclopia there is more or less complete lack of the primordial cartilage in front of the cord; in synotia only the tympanic ossicles and the anterior portion of the body of the sphenoid bone are wanting.

There is no doubt that this deformity does not appear until about the 3d month of gestation. — *Dublin Jour. Med. Scien.*, Jan., 1889.

Blake (C. J.) on a New Form of Clinical Tuning-Fork.—Various methods have been employed to obviate the overtones in setting the usual form of tuning-fork vibrating; and which tones greatly interfere with the usefulness of this instrument in testing normal and abnormal acuteness of hearing. One method is by a blow from a hammer belonging to the fork, and limited to a definite space traversed in striking. Politzer affixed clamps to the tines, which, by moving up and down, gave the advantage of change in tone as well as doing away with the over-tones. The French forks have the tines inclined towards each other, and are set in action by drawing between them a bar of wood or metal These all have objections. They are either unreliable or inconvenient. The new form consists in weighting the extremities of the tines by adding about one half to their diameter at this point. — *Boston. Med. and Surg. Jour.*, Dec. 20, 1888.

Eichberg on Deafness from Syphilitic Disease of the Labyrinth. — The deafness appeared six weeks after infection. There were some granulations in the throat about the Eustachian tubes, which had existed two years. Antispecific treatment and hypodermatic use of pilocarpine from $\frac{1}{4}$ to $\frac{1}{2}$ of a grain very much improved the hearing which was zero $\frac{1}{4}$ inch for watch in one ear and contact in the other.—*Cincinat. Lancet-Clin.*, March 2, 1889.

Steves (H. F.) on Maggots in the Eye.—Two days after a ride in a street-car of Birmingham, Ala., where blowflies had been noticed, a child two weeks old presented severe inflammation, and on opening lids considerable hemorrhage took place, with the discharge of a maggot. The next day the eye was well.—*Weekly Med. Rev.*, Feb. 6, 1889.

Dibble (L. R.) on Evulsion of Pterygium by the Use of Strabismus Hooks.—This refractory disease has been treated in many ways. The usual method, that of shaving the attachments from the corner and then bringing the edges of the wound together by fine sutures, often fails. But evulsion by means of the strabismus hook leaves a surface nearer normal and has given so far more satisfactory results.—*Kan. City Med. Index*, Oct., 1888.

Wolfe (J. R.) on Total Staphyloma of the Cornea Corrected by an Operation.—A traumatic total anterior staphyloma of the eyeball was treated by removing an oval-shaped flap from the horizontal meridian of the cornea. The cataractous lens removed, the lips of the wound were brought together by fine silk sutures and the lids closed by adhesive plasters. On the third day the bandages, plasters, and sutures were removed, and the edges of the wound were found closely applied and the eye returned to normal size and shape. After 8 days the patient was discharged. And now nearly 4 months have elapsed without any return of pain, and the eye retains a good natural size.—*Lancet*, March 23, 1889.

D'Oench (F.E.) on a Peculiar Case of Detachment of the Retina.—The right eye had failed in vision rapidly for two weeks. The ophthalmoscope showed an extensive detachment of the retina extending past the macula towards the disk, the fovea centralis appearing as a dark-red spot in the detached portion. The peculiarity consisted in the presence of numerous small white dots, most numerous near the periphery, of the size of a pin-head and less, and not confluent. The patient had perception of light in detached portion. The tension was normal. Cases similar have been noticed, but are very rare. It is probable these dots are due to the acute degenerative process. No albumen nor sugar was found in the urine.—*Med. Record.*, March 9, 1889.

SURGERY.

Powers (C. A.) on Kocher's Method of Reducing Subcoracoid Dislocations of the Humerus; a Plea for its Employment in Every Recent Case.—Suppose the right shoulder to be the seat of injury. The patient is seated and the surgeon kneels beside him. With his left hand he grasps the arm of the patient just above the elbow. The patient's forearm being flexed to a right angle, the surgeon firmly seizes the wrist with his right hand. Then adducting the elbow to the body he utilizes the lever furnished by the forearm and rotates the arm out until firm resistance is met (practically until the forearm makes an angle of ninety degrees with the antero-posterior plane of the body). Now, with the arm still strongly rotated out, he brings the elbow forward and upward in the sagittal plane across the chest, and finally rotates the arm in, and places the patient's hand on his opposite shoulder.

This procedure Dr. Powers amends by placing the patient squarely on his back, with both shoulders resting on a firm table, and as there is a great tendency for him to turn his body to the affected side during the external rotation of the arm, I think it well that the opposite shoulder be held down. This may be done by a bystander. It is well, also, that downward traction be added to adduction of the elbow in the first movement.

Its Employment at the Chambers Street Hospital, New York.—Early in 1883 a description of the method came under the notice of Dr. William T. Bull,[1] the attending surgeon to the hospital, and under his direction its employment was commenced and continued. The first case was that of a man, seventy years of age, who presented himself at the hospital March 3, 1883. His subcoracoid humerus was so quickly and easily replaced in its normal cavity that surprise and delight found place in the minds of all who observed the procedure. Since then the method has been used to the exclusion of all others. The results in the first six months were published by Dr. Charles A. Jersey, in the *New York Medical Journal* for September 23, 1883, in an article entitled, "Twenty-one Cases of Subcoracoid Dislocation of the Humerus Reduced by Kocher's Method." In seventeen of the twenty-one cases the reduction was effected at the first attempt, in the other four the bone went back at the second, third, fourth, or fifth attempt, respectively. In none was an anæsthetic used.

During the five years ending with October 1, 1888 (the five years following the publication of Jersey's paper), 173 recorded cases of recently dislocated humerus find place in the history books of the Chambers Street Hospital. Of these, 44 were subglenoid and 129 subcoracoid.

The results of treatment in the subcoracoid cases are as follows:

Without ether, Kocher's manipulation, successful at first attempt	98
Without ether, Kocher's manipulation, successful at second attempt	6
Without ether, Kocher's manipulation, successful at third attempt	8
Without ether, Kocher's manipulation, successful at fourth attempt	1
Failed without ether, with ether successful at first attempt	6
Failed without ether, traction at a right angle, successful	5
Failed without ether, foot in axilla, successful	1
Failed without ether, the head undergoing extreme external rotation,[2] slips into axilla and is then reduced as axillary	1
Kocher not tried, success by traction at right angle	3
	129

We thus see that of the 126 cases in which the procedure was resorted to, it was successful in 98 cases, or more than 77 + per

[1] To Dr. Bull should be accredited its introduction in this country.

[2] Doubtless a case in which the capsule was severly torn.

cent., at the first attempt, and that without the aid of an anæsthetic. Let us, however, make due allowance for the fact that these dislocations were reduced by some twenty-five different gentlemen, each of whom numbered in this list his "first case," on which, perhaps, he failed at first attempt.

Let us assume, moreover, that the list is not entirely free from diagnostic errors, and that more than one case which is classed as subcoracoid was, in reality, an axillary luxation.

From the personal reduction of a not inconsiderable number of these cases, and the observation of many more, I am fully prepared to share the opinion of the authors to whom I have referred, that "in a recent simple case, the manipulation should prove successful at the first attempt, without anæsthesia."

In none of these cases was an injury inflicted on the axillary vessels or nerves.

Recital of them would be devoid of interest. Most of them occurred in muscular laborers[1]; many of the patients presented themselves in a state of intoxication, and either strenuously resisted manipulation, or absolutely refused it without the influence of an anæsthetic. These considerations aid in accounting for the "first-attempt" failures, for those cases in which ether was given.

Causes of Failure.—1. In muscular rigidity. 2. Extensively torn capsule. 3. Fracture complicating the dislocation. 4. Error in diagnosis. 5. Failure to properly adduct the elbow, or to sufficiently rotate the arm out. 6. Inward rotation of the arm before completion of the third movement. 7. Dislocation of such long standing that adhesions have formed about the head and neck of the bone.

Conclusions.—1st. Of the various luxations which the humerus undergoes the subcoracoid is much the most common.

2d. The method to be employed in its reduction is, *par excellence*, that of Kocher, and it should be used in every recent case.

3d. The procedure is logical and safe. It may easily and rapidly be carried out. Its careful, accurate, and thorough employment will almost invariably assure success at the first attempt.

4th. It will not succeed in those cases happily uncommon, in which the capsular ligament is severely torn.

5th. The patient should be in the dorsal position.

6th. An anæsthetic is unnecessary.

7th. The aid of a skilled assistant may be dispensed with. It is advisable that the opposite shoulder be steadied, but this can be done by a layman.

8th. It is attended with the least possible pain to the patient.

9th. It is practically without danger to the important vessels and nerves.

10th. The question as to whether its success depends on the integrity of the anterior or of the posterior part of the capsule must yet be considered *sub judice*.

11th. It rarely succeeds in the subglenoid form.

12th. It is applicable to the intracoracoid cases, but in those the elbow should be placed behind the posterior axillary line (Kocher) and external rotation should be maintained for two or three minutes (Carafi).

13th. In all cases in which much resistance is met with during the early part of the second movement, the position of external rotation should be steadily maintained for a short period before bringing the arm forward and across the chest.—*Med. Record*, March 30, 1889.

White (J. A.) on Hearing Restored after Deafness of Twenty-five Years' Standing, by a Surgical Operation.—The patient was a man who had been wounded at the battle of Chancellorsville, and in consequence lost the hearing of the left ear. The bullet struck him in the cheek in front of the ear, passed into the bone and out through the left mastoid process, crushing the bony parts of the external meatus auditorius in its passage. The union of the crushed fragments resulted in a bony occlusion of the meatus.

In December, 1888, he applied to Dr. White to see if there was any chance of restoring the defective ear. On examination it was found that he was perfectly deaf to all extraneous sounds, such as voice, watch, etc., but he could hear the tuning-fork when placed at the apex of the head or on the teeth. As the nerve perception by bone-conduction was good, Dr.

[1] It seems unnecessary to call attention to the patent fact that before attempting the reduction of any dislocation the patient's muscles should be thoroughly relaxed. In ignorant or frightened subjects this is often difficult of attainment.

White determined to perform an operation in an endeavor to restore the external meatus. The bony callus was attacked with mallet and chisel, and a shallow opening in the line of the meatus was made by chipping away the bone. For fear of wounding the membrana tympani, the chisel was then laid aside, and the operation was completed with the aid of the dental engine by dental burrs and drills. When the opening was sufficiently large and deep to obtain a view of the drumhead, it was found that the deepest portion of the osseous meatus, about one eighth of an inch in front of the drumhead, had not been filled up, and a small space existed between the inner wall of the bony obstruction and the drumhead. The artificial meatus was made as large or larger than the normal passage-way, and the drumhead was almost normal in appearance.

There was considerable irritation about the parts for some days, which soon subsided. *Hearing* gradually improved, until ten days after the operation, when a loud whisper was distinctly audible to the patient.—*Va. Med. Mo.*, April, 1889.

Varicocele Producing Total Suspension of Sexual Function.—M. Segond related before the Société de Chirurgie an interesting case of varicocele which produced total suspension of the sexual function. A young man of twenty-six came to him for impotency, which was absolute. Every medical agent, electricity comprised, was tried without success. In examining more attentively the patient he came to the opinion that the voluminous varicocele situated on the left side was not altogether foreign to his condition, especially so as the man assured him that when in the recumbent position the veins degorged, and erection was possible; but immediately he assumed the upright position, power was gone. The radical cure of the varicocele was immediately proposed and accepted, and at the end of two months all trace of impotency had disappeared. M. Segond added that he was well aware that this case was not exceptional, as Vidal de Cassis had already mentioned a similar case, and Parona published last year three cases of impotency due in his opinion to dilatation of the dorsal vein of the penis. MM. Berger and Terrier would attribute the cause of the impotency rather to hypochondria depending on the condition of the patient.—*Med. Press*, March 13, 1889.

Sutton (B.) on an Erectile Tumor Removed from the Mamma of a Boy, æt. 17.—At birth a cutaneous nævus was noticed connected with a small subcutaneous lump. This gave no trouble till the boy was seven years of age. It then began to enlarge, and continued to do so for the next ten years. A few days before applying to the hospital the tumor began to bleed. The hemorrhage had considerably reduced the patient, and blood was oozing from the tumor when admitted to the hospital. Next day Mr. Sutton excised the tumor. Numerous vessels (60 in all) required a ligature. Patient left the hospital well in twenty-three days. Three months after he had a sound cicatrix. The tumor was three inches and a half in diameter, and composed of tissue resembling the corpus spongiosum penis, mixed with glandular tissue and fat. He pointed out that erectile tumors of the mamma were rare.—*Med. Press*, March 13, 1889.

MISCELLANY.

Cantlie (J.) on the Rational Treatment of Pericardial Adhesions.—A man, twenty-eight years of age, when a boy of fifteen suffered from an attack of rheumatic fever. He had a contemporaneous attack of pericarditis. After the acute symptoms subsided he was taken by his medical adviser to a well-known physician. The result of this consultation was that a very grave prognosis was arrived at, and the boy's parents were informed that his only chance of life was extreme care. He was sent to France to school, the conditions obtaining there being believed to be more favorable to the maintenance of health than by his staying in England. Being away from parental supervision, he, boy-like, neglected care and went in for gymnastics and sports of all kinds, commencing immediately upon his arrival—that is, within five months after his attack. He returned to England, and after medical inspection was pronounced much better. He was again cautioned to conserve his energy, but he disobeyed instruction in the most reckless manner, going in for running, cricket, football, and volunteering enthusiastically. He afterward became an engineer, and went to China, where I met him. He told me his history, and—not because he was ill—I examined his heart. No valvular disease was present, and the

only condition found to be abnormal was a slight increase in the pericardial area of dulness. The case has set me thinking as to the rational treatment of pericardial lesions generally. If adhesions, the result of inflammation, takes place in a joint, early movement of it is the A B C of treatment; if neglected, a stiff joint is the result. When recently-formed pericardial adhesions take place, why should the opposite condition be insisted on? Prolonged rest will allow of the adhesions firming up into fibrous patches of adhesion, rendering it impossible for the heart to execute more than a limited amount of movement; whereas early cardiac excitation will bring more movement to bear on the recently-formed adhesion tissue, and to pull it out into strands of tissue, in place of allowing it to heal as it chooses in patches. In fact, a filamentous in place of a membranous adhesion will be more likely to be induced, thereby allowing more freedom of cardiac movement. When valvular trouble is present in conjunction with pericardial adhesion, encouragement to take exercise will no doubt cause trouble; but with pericardial adhesions, pure and simple, it seems only rational that benefit may ensue from gradually increased exertion at a reasonably early period during convalescence.—*Br. Med. Jour.*, April 13, 1889.

Hunter (W.) on Spontaneous Expulsion of a Laryngeal Tumor by Coughing.[1]—During a week in July last a cab proprietor had a severe wetting. From this time he noticed his voice became hoarse. The hoarseness increased until Christmas, when he could only speak in a whisper. There was considerable cough and uneasiness, with pain, referred to the episternal notch. The degree of hoarseness used to vary suddenly and greatly, but never disappeared. He never had any difficulty of breathing, or suffered sufficient discomfort to apply for medical treatment.

The man's condition remained unaltered until the evening of March 12th, when he had a more than usually severe attack of coughing, which ended in the expulsion of a solid substance, accompanied with some blood. The voice immediately improved, regaining its natural tone, and he felt altogether much relieved.

It was a solid, softish growth, about the size of a horse-bean, fairly regular in shape, covered entirely by healthy mucous membrane, with the exception of a small circular patch about the size of a split pea, which was red, raw, and granular, and was plainly the site of attachment. On section, the growth looked like a fibroma, but it was not examined microscopically.

The man's larynx appeared on March 18th as follows:

There is a little swelling of the right arytenoid cartilage. The glottis is unduly expanded, especially on the left side, and the left cord is very much narrowed, apparently from pressure—in fact, it is reduced almost to a line. There are a few dilated vessels on each cord. A good view of the trachea, as low down as the third ring, was obtained, but the mucous membrane was smooth, and showed no sign of having recently given attachment to a growth. The tumor had evidently pressed on the left cord, and expanded that side of the glottis. It probably grew from the cord, but the site of the attachment was not evident. It might, however, have arisen just below the glottis, as there were no signs of any recent growth from the ventricular bands or upper part of the larynx, which was well seen. There was no sign of any other growth. Both cords move freely with respiration and phonation, but during the latter, notwithstanding some over-adduction of the right cord, the glottis is not quite closed, on account of the expansion of the left side.—*Br. Med. Jour.*, April 13, 1889.

[1] A similar case was reported by Charazac in the *Gaz. des Hôp.*, Oct. 6, 1887. See MEDICAL ANALECTIC, 1887, p. 525.

BOOK NOTICES.

Clinical Atlas of Venereal and Skin Diseases, Including Diagnosis, Prognosis, and Treatment.—By Robert W. Taylor, A.M., M.D., etc., etc. Lea Brothers & Co., Phila., 1888.

Parts III., IV., V., and VI. are now before us, and they fully maintain the commendable excellence of the two first numbers.

Part III. deals with various syphilides and hereditary syphilis, closing with ten pages devoted to the treatment of syphilis.

In Part IV. is commenced a consideration of diseases of the skin. Primary and secondary lesions are studied, and the classification, adopted by the American Dermatological Association, is presented.

There are then studied consecutively, erythema multiforme and nodosum, eczema, acne, psoriasis, and tinea favosa.

Part V., continuing diseases of the skin, treats of pediculosis, erythema facei and circinatum, herpes

iris and erythema serpens, tinea versicolor and tonsurans, pityriasis rubra, dermatitis exfoliativa, and impetigo herpetiformis.

Part VI. takes up urticaria, pemphigus, tinea trichophytina Barbae, tinea circinata, echthyma, lupus erythematosis, and herpes zoster.

As we have already said, the work is admirable, text and plates, still we cannot but feel that a certain element of fraud enters into any work where credit is not given *in situ* for borrowed material, be it plates, cuts or text.

To be more specific, it is our individual opinion that explicit credit, for borrowed plates or cuts, should be given either on the plate or cut, or in a prominent way in the neighboring and descriptive text. No one except a dermatologist, familiar with them, for instance, would appreciate the fact, from a casual perusal, that most of the plates and many of the cuts in the present work were borrowed. For example, let us take the illustrations of Part IV.: Taylor's plate, xxv., showing erythema nodosum, is original with the New Sydenham Society's atlas; plate xxvii. of Taylor is New Sydenham original plate xvi.; Taylor's plate xxvii. is New Sydenham plate xxvi.; Taylor's plate xxix. is New Sydenham plate xiv.; Taylor's plate xxx., fig. 2, is New Sydenham plate xvii.; while Taylor's plate xxxi. is original in Hebra's atlas, and is reproduced in the New Sydenham collection, plate i. Among the cuts, figure 27 on page 236 is also from the New Sydenham collection. Now *nowhere* on the plates or in the text is the *slightest allusion* made to the original authorship of these illustrations. Any objection which might be urged against crediting the source of the illustration upon the plate cannot be urged against giving due acknowledgment in the explanatory text. For instance, what harm can there possibly be in printing instead of "In plate xxix. psoriasis is portrayed in a very graphic manner," Taylor, p. 234, something like this: In plate xxix. [reproduced from plate xiv. of the New Sydenham atlas] psorasis is portrayed in a very graphic manner, etc. No amount of acknowledgment in introductory preface or concluding index can take the place of prominent and contiguous acknowledgment of borrowed material. While nothing is further from our mind than imputation of any intentional unfairness on the part the of our distinguished author, a man who undertakes to write a text-book cannot be too particular to avow the lesser luminaries which help to intensify the dazzling effulgence of the greater orb. R. W. A.

The International Medical Annual and Practitioner's Index.—A Work of Reference for Medical Practitioners. 8vo. 546 pp. E. B. Treat & Co., New York, 1889. Price, $2.75.

The title of this book indicates its aim and scope. It is the result of compilation almost entirely, although the twenty-six associated editors often add comments, and occasionally original observations.

Of the collaborators most are English; some of whom are well known—Dowse, Fenwick, Hutchinson, Jr., Mackenzie, Robson, Saundby, and Savage, among others. The American associates are few. They are: H. D. Chapin, C. L. Dana, and J. R. Leaming.

The first part of the book is devoted to new remedies and newly discovered applications of old ones. This part also contains articles on mechano-therapeutics (massage) and electro-therapeutics.

In the second part of the book the names of diseases are arranged in alphabetical order, and new points in the treatment of each are appended. The third part contains miscellaneous information of a kind very frequently required in the routine of practice. Of its class the book is one of the best, combining compactness and completeness in a way that few do. A general index with cross-references and an index of diseases greatly enhance the utility of the book.

Suggestive Therapeutics.—A Treatise on the Nature and Uses of Hypnotism. By H. Bernheim, M.D., etc. Translated from the second and revised French edition by Christian H. Herter, M.D. 8vo. 420 pp. G. P. Putnam's Sons, New York and London, 1889. $3.50.

Emanating from an authority on this subject, a treatise like the one under consideration will be fully appreciated by readers who are often disappointed and sometimes disgusted by the random, poorly digested articles on the same subject with which our medical and lay periodicals have been from time to time filled.

If such a subject *can* have a scientific basis, it is approached nearer here than anywhere else in medical literature. That it *can* have a rational or scientific basis in the present state of our knowledge, most of us doubt; that one may be put under it at some future time is possible, if earnest, scientific workers like Charcot and Bernheim persist in their study and experiment. The hope that we shall ever reap positive, practical benefits from it which will at all compensate for the quackish, criminal abuse of it and the individual cases of moral degradation it will develop, is also problematical.

In these days of "Christian science" and "mind cure" (and suggestive therapeutics is nothing else), the publication of this work is timely, in that it opens our eyes to the germ of good in the present craze, and also puts us still more on our guard against its innumerable abuses and dangers and limited applicability.

In the first part of the book the author describes the method employed in inducing hypnotism and the different manifestations which may be produced in hypnotized subjects. A short historical sketch follows. He next examines into the theoretical views put forth on the subject, and states his own opinion upon the psychological mechanism of the phenomena. Next he examines the applications of the doctrine of suggestion to psychology, to legal medicine, and to sociology in a general way.

In conclusion, he makes a special study of suggestive therapeutics, and relates his personal observations.

About the only serious fault which can be found with the book, is that not enough stress is laid upon the great and underestimated danger connected with public exhibitions of hypnotism, and the employment of this powerful agent for illegal, immoral, or criminal purposes.

Here in America would-be disciples of the Bernheim school will find their subjects less impressionable than the lower classes of Europeans, and will become aware that, with this lack of docility on the part of patients, there is an almost total lack of that blind, reverential trust in the physician, so essential to success in this field.

On reading the book, one can but suspect that on more than one occasion Bernheim himself has been the victim of duplicity on the part of the subject.

The work of the translator cannot be too highly commended; and press-work, paper, and binding are of the best. R. W. A.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

VOL. VI., No. 19. May 9, 1889. WHOLE No. 119.

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PATHOLOGY AND MEDICINE.

Noble (S. C.) on a Case of Rupture of the Left Ventricle; Death at the Expiration of Five Days and a Half.—A man aged sixty-one, while walking home on March 9th, was seized with faintness and nausea, accompanied by pain at the præcordia. Suddenly he became insensible and fell. When seen by me fifteen minutes after the occurrence, he had regained consciousness, but was deadly pale and extremely collapsed; pulse 38, irregular, and remarkably feeble. While being taken home he vomited freely, but this was not followed by any reaction. He was put to bed, heat applied to the extremities, and brandy given. Extreme pallor, sickness, and collapse persisted; the skin was bathed in a most profuse cold perspiration, and there was much restlessness. The patient only complained of pain at the præcordia. After four hours, sweating ceased and the pulse slightly improved.

During the night there was much unrest, but on the morning of the 10th there was some amelioration in the symptoms, though great weariness was felt; pallor was less extreme, pulse 44, and a little fuller, and præcordial pain diminished. By evening all collapse and pain had gone, and the pulse was 66, full and regular.

On the 11th he had further improved, and had had good sleep. There was some cough, accompanied by soreness behind the sternum; the temperature was 102° F. On examination of the chest the heart's area of dulness was not increased; there was no *bruit*, but the sounds were muffled, and the impulse was feeble. There were some *râles* on the front and back of the right chest; the percussion note in front was slightly hyper-resonant; the number of respirations normal. The urine was free from albumen, but high-colored and loaded with lithates.

On the 12th and 13th he was most comfortable, and took food well; the pulse was 60 and regular, and the temperature 99.4°; but during the night of the 13th he was very restless, and on the following morning a grave condition had again shown itself. Pallor had increased, pulse was 60, small, and very irregular; respirations were 40 to 42, and thirst urgent; yet no pain was complained of. His bowels had been moved after some considerable effort. As the day advanced exhaustion increased; respirations became 60 and "Cheyne-Stokes" in character, and ultimately he died on the morning of the 15th, having but a moment or two before spoken with much vigor and cheerfulness.

On making a *post-mortem* examination of the thoracic viscera there was found emphysema of the free margins of both lungs, that on the left overlapping the præcordia, and there were cartilaginous plates at both apices on the visceral pleuræ. In the pericardium there was a great excess of clear serous fluid, and on raising the heart there was found an immense, firm, undecolorized coagulum, which would more than fill a large saucer. Towards the base of the left

ventricle was a vertical laceration, large enough to admit three fingers, and extending through the entire thickness of the wall, which was here soft and friable. There was a large quantity of fat on the heart.

This case is of special interest from the fact that the patient lived for five days and a half after the laceration. That the actual rupture through the ventricular wall took place at the time of the fall seems proved by the suddenness of the seizure, followed so immediately by profound collapse and shock, alarming syncope, cardiac embarrassment, and death-like pallor. That it was due to degenerative changes is evidenced by its situation, the friability of the wall, and the absence of traumatic causes.

Whether the laceration was at first small, and subsequently extended; whether the rallying was due to the wound becoming plugged with coagula so that extravasation was temporarily arrested; or whether, owing to the strain of difficult defæcation on the fifth day, or some other cause, the coagula were displaced and further extravasation ensued, are points of great interest.

The patient was anæmic, especially during the last few months of his life; a total abstainer, of active habits, but excitable. He had had pain at the præcordia two hours before he fell, but never previously a day's illness.

This case seems to afford room for reflection whether, in instances of cardiac degeneration, sudden death should be so frequently attributed to simple heart failure.—*Br. Med. Jour.*, April 6, 1889.

The Pneumonia Epidemic of Middlesbrough.—The long-expected report of Dr. Ballard on the epidemic of "so-called pneumonia" at Middlesbrough is at length published. It is only an interim report, but it gives the principal palpable facts investigated by Dr. Ballard of the remarkable disease which has alarmed the public and been fatal in a period of six months to 369 persons, of whom no less than 288 were males. This number includes the deaths from the same disease that happened in three adjoining local-board districts. Epidemic pneumonia is not a new idea to our readers or to the Local Government Board. But the special investigation that has been made by Dr. Ballard, to whom we owe other investigations of much public importance, is the first that has been instituted. We must defer a detailed notice of the subject till the appearance of the full report. But a few of the main facts must be given without delay. Middlesbrough has grown like a mushroom, till it has now a population of 69,255. Dr. Malcomson, the medical officer of health, first notified to the Board in May last that an epidemic of pneumonia prevailed, and was very fatal. Dr. Ballard gives the mortality in six four-weekly periods from February 25th to July 14th, as follows: 35, 57, 51, 65, 106, 55. In age-groups the deaths were: up to fifteen, 35; fifteen to forty-five, 155; forty-five to sixty-five, 136; over sixty-five, 43. One of the most striking features of the mortality is its terrible incidence on the *male* sex. As we have said, of the 369 deaths no less than 288 were in males, whereas in ordinary pneumonia the mortality of the sexes is not very unequal. The clinical features of the disease are, generally, sudden attack, rise of temperature, pain in side, rapid pulse and breathing, usually vomiting or diorrhœa, delirium, accompanied or soon followed by the physical signs of pleuro-pneumonia. The expectoration is at first "rusty," but afterwards of a prune-juice character. The fresh lung-juice has been examined by Dr. Klein, who finds in it a hitherto undescribed bacillus, which he regards as specific. In the fatal cases death occurred often in from three to five days. The post-mortem appearances were those of lobar pneumonia, with invariable effusion of lymph on both costal and pulmonary pleura, following coagula in the heart, apparently of ante-mortem formation; the spleen invariably pulpy; and ecchymoses of the mucous membrane of the stomach. Dr. Ballard regards the disease as a specific febrile one, and *infectious*. He promises to give conclusive evidence on this point in his full report. He regards it as communicated either through direct relation of individuals, or through sewers contaminated with sputa or other excretions of the sick, or through food. Exposure to "slag dust" was regarded by many as a cause; but Dr. Ballard only considers it a predisposing or assisting cause. The lesson of Dr. Ballard's investigation is that the disease must be regarded as infectious, and that the same precautions must be taken against it as against other infectious diseases capable of contaminating air, sewers, or food.—*Lancet*, April 13, 1889.

Holt (L. E.) on the Relation of Bacteria to Diarrhœal Diseases in Infancy.—The author accepts the doctrine that we are concerned most of all, in the gastro-intestinal disorders of infancy, with the development of abnormal bacteria, but that as the first step there is a failure of complete digestion and perfect absorption.

Mechanical diarrhœa, from the presence of foreign bodies, or food which acts as such to infantile digestion, and that resulting from the ingestion of poisonous ptomaines, are probably the only varieties to be excluded from this class.

The anatomical changes are those of inflammation of the gastro-intestinal mucous membrane; but the lesions are the results, either directly or indirectly, of the micro-organisms. Since micro-organisms are found in numbers only superficially, except where ulcers exist, it seems most likely that their action is an indirect one through their ptomaines.

As to the exact nature of the processes of putrefaction which take place in the intestine, and the bacteria which produce the different forms, we are as yet almost in entire ignorance.

One clinical form of diarrhœal disease—viz., true cholera infantum—has many features which point to a specific germ as a probable cause.

Two things are essential to active bacterial growth—the entrance of living germs in numbers, and a proper soil for their development. Prophylaxis must have regard to both these conditions.

Germs are to be excluded by sterilizing milk for all children under two years, by absolute cleanliness of bottles and every thing with which the milk comes in contact, and by securing pure air. Tompkins found in Leicester, England, that in one section of the town where diarrhœal diseases were very prevalent there were from three to six times as many bacteria in the air as in other sections. The water supply was the same for all, and the food not essentially different.

Equally important is cleanliness of the mouth. Van Puteren found in infants suffering from thrush that the number of bacteria in the stomach was forty times as great as when this condition was absent.

To secure a soil unfavorable for bacteria we must have healthy digestion and absorption. This means a great deal. To secure it we must, in the first place, build up the infant's constitution; secondly, food suited to the powers of the digestive organs should be given; thirdly, regularity in feeding must be insisted on, and night nursing and feeding stopped as early as possible; fourthly, the stools should be inspected to see whether what is given is properly absorbed; fifthly, all minor derangements should be attended to; sixthly, during the hot summer season the amount of food should be materially reduced, and infants should be allowed water freely.[1]

As to treatment, three distinct indications present themselves:

1. To nourish the patient.
2. To combat the abnormal bacterial growth.
3. To treat the lesions.

All these indications must be considered if success is to be the result of our efforts. The force of the different indications may vary in different stages of the morbid process; thus, early in the disease the second indication may be the most important, while, later on, the third indication comes into great prominence. In all stages we have to deal with a very complex process, and its management will never, I think, be reduced to so simple a thing as the discovery of a pathogenic microbe and the giving of its appropriate germicide.—*N. Y. Med. Jour.*, April 13, 1889.

A Case of Leprosy in Dublin.—At a meeting of the Section of Pathology on February 15th, Dr. O'Carroll showed a case of leprosy. The disease had first shown itself in Hong Kong twenty-two years ago; but the patient, an Irishman, had previously been in India and the Cape. The disease was of the mixed form. The eruption were distinguishable into primary

[1] Under this last point I wish to call attention to an experience of Dr. David Little, of Rochester, N. Y., which he published in "The Transactions of the Medical Society of the State of New York," in 1884.

In an orphan asylum in his city, where every previous summer had witnessed a number of deaths from diarrhœal disease, he directed that infants should be fed at three-hour intervals during the day, and should have nothing at night. Water was allowed freely at all times.

The season passed without a fatal case from diarrhœal disease. At the close of the season he remarked to the sister in charge that the new rules in feeding had proved beneficial. She replied: "*Yes, but it did seem rather cruel to feed the infants only three times a day.*" These were the directions as she had understood them and as they had been rigorously carried out. The moral is plain.

and secondary ones—the former being tubercular and macular, and more or less generally distributed over the head, trunk, and upper part of the limbs; the latter bullous or pemphygoid in character, and affecting only the peripheral distribution of the ulnar and external popliteal nerves. Similarly an ulceration of the palate was pointed out as an example of a primary or specific lesion, while a caries of some bones of the feet was suggested as being secondary and analogous to the "perforatiag ulcer" of tabes dorsalis. This division of the more prominent phenomena into specific and secondary was further supported by a series of examinations for the specific bacillus lepræ, for which, however, Dr. O'Carroll did not yet claim the authority of completeness. The more general interest of the case lay in the fact that the disease had been established for so long a period without any marked mental or physical failure other than inability to get about briskly on account of the chronic caries in one or other foot, and the manual awkwardness due to the clawed condition of his hands.—*Dublin Jour. Med. Sci.*, March, 1889.

Martin (S. C.) on a Pregnant Cause of Failure in Vaccination.—Some time ago an article appeared in a medical journal, severely deprecating the ordinary method of performing the slight operation of vaccination as unscientific and dangerous in the extreme, because offering a free and hearty welcome to the hordes of ravening germs that are everywhere constantly on the watch for a chance of ingress to the human body. It then proceeded to lay down certain sapient rules to be followed, that all such dangers might surely be avoided and the operation taken from the realms of malpraxis and placed upon a scientific basis. One was directed to most thoroughly wash the arm of the vaccinee, the instrument to be used, and his own hands with a solution of carbolic acid. This article was quite freely copied in the medical press of the country, and similar counsel has likewise appeared from time to time, merely substituting for the carbolic acid, corrosive sublimate, that being the latest favorite among germicides. When such advice is thus freely published and, what is worse, followed, it is high time that a decided protest be entered. For advice that makes pretence of being ultra-scientific, none could well be more grossly unscientific and absurd. Do those who give it or follow it reflect for a moment on what they are trying to accomplish by vaccination—that the introduction of pathogenic germs into the system is precisely the end aimed at by that procedure? Let them do so, and then calmly consider the propriety of saturating the soil in which these germs are to be sown, and every thing coming in contact with them, with the most powerful and perfect fluid germicide science has produced. The satisfaction of having performed a thoroughly antiseptic operation may thus be attained, and the wound may heal admirably, but there will be no *vaccination*.

Far be it from me to say one word detracting from the most thorough *asepsis* in connection with vaccination. Thorough cleanliness should be observed and a foul lancet most carefully guarded against.

All this can be perfectly accomplished by observing the following simple directions: Wash the arm thoroughly with plain soap and water, hold your lancet, if you use one, for a moment in a flame, which will as thoroughly sterilize it as an ocean of corrosive sublimate or carbolic-acid solution could, and when the lancet has become cool, simply vaccinate your subject; but in the name of all that is rational, do not use a drop of any fluid germicide as an adjunct. Then, if you have not chosen a hot-bed of infectious diseases for the scene of the vaccination and have used proper virus upon a decently healthy subject, you will have the consciousness of having taken every essential precaution, and, what is perhaps of *some* importance, infected your patient with the cow-pox, your sole motive for having to do with him at all.—*Boston Med. and Surg. Jour.*, April 13, 1889.

Post-Mortem Warts.—Post-mortem warts are now pretty generally regarded as local tuberculosis, the result of inoculation. The presence of bacilli has been demonstrated in several instances. The tubercles consist chiefly of granulation tissue, occasionally with giant cells and with papillomatous outgrowths of the epidermis, which give the tubercle the wart-like character. They are met with in persons who perform many post-mortems, and in those whose business brings them into close contact with animals and animal products. Their occurrence is by no means infrequent. Abroad it is quite common to see the hands of the demonstrators of pathology (and

more especially the attendants in the autopsy rooms) disfigured by these structures. According to Mr. Hutchinson, however, these warts are a form of lupus.—*Med. Press*, April 3, 1889.

Targett on Diffuse Calcification of the Liver.—A man of 62 had had a tumor in the epigastric region for seventeen years, which was very hard but not tender, and did not interfere with his work as a farm laborer. Four months before death he developed an empyema on the right side, for which he was treated in the hospital. At that time the abdomen presented a swelling of stony hardness in the epigastric region, which moved with respiration, and appeared connected with the liver. There was no ascites, but the veins over the upper part of the abdomen and the lower part of the chest were enlarged and varicose. There was no jaundice until two days before death, which resulted from facial erysipelas. The clinical report was very incomplete and the condition of the urine was not mentioned; but at the post-mortem examination the kidneys looked normal, though much enlarged. The spleen was four or five times its usual size; the liver was firmly adherent to all the surrounding parts; after removal it weighed 66 ounces. The left lobe was very much enlarged, and was the cause of the epigastric swelling. The capsule was much thickened, and the substance of the liver so hard that it had to be sawn into sections. The greater portion of the organ was then found to be replaced by fibrous tissue, which was infiltrated with calcareous deposed of carbonate and phosphate of lime and a large proportion of organic matter, but did not contain cholesterin or bile acids. Microscopic examination of the least affected parts of the liver showed changes like those of monolobular cirrhosis, and there were many groups of small round cells in the strands of fibrous tissue. One striking point was the amount of new tissue in the centre of the lobules spreading out between the rows of liver cells. The other parts of the liver were decalcified and examined, but they showed little more than fibroid tissue. There was no caseation; no gummata or evidence of parasites could be found. He considered that the thickening of the capsule, together with the amount of fibrous tissue in the interior of the organ, were suggestive of the primary change being syphilitic, but there was none of the cicatricial contraction so commonly found in old syphilitic livers. The clinical history did not mention syphilis or alcoholism.—*Lancet*, April 20, 1889.

Morbid Changes in Diabetes.—Dr. P. Ferraro, who has made several researches on the subject of the changes produced in the different organs of the body by diabetes, has recently published the results of similar investigations in a fresh case, the eighth of the series. The arteries were affected with chronic endarteritis; in the lungs there were morbid changes not due to bacilli; in the stomach and intestines the mucous membrane was atrophied; the pancreas was transformed into a firm, compact mass of a fibrous or cicatricial character; in the parenchyma of the liver and the spleen pulp there were also signs of atrophy. Here, therefore, as in the other cases examined, the digestive organs were most of them affected to a greater or less extent, while the nervous system was not apparently the subject of any morbid changes. Dr. Ferraro considers the exhaustive study of the morbid histological changes in diabetes very important, and believes that we shall not arrive at any definite conclusion as to the etiology of this disease until our knowledge of the conditions under which sugar is formed and distributed in the body in a state of health is very much further advanced than it is at present.—*Lancet*, April 20, 1889.

On the Treatment of Inebriate Women.—Mrs. L'Oste gives a summary of twenty-seven years' experience in the treatment of cultured female inebriates. The "tapering off" process had proved a failure, and immediate abstinence had been effectual and safe. At first both sexes were treated, but experience soon showed that homes for ladies and gentlemen should be separate. Inebriety was a disease often hereditary, and the germs frequently noticed in children. When not inherited, obstetric troubles were the chief cause of the disease. Fashionable pick-me-ups, reputed non-spirituous, but really intoxicating, were a common cause. While under the influence of the disease the sufferers were not responsible for their actions, and sometimes the crave was irresistible. A special study of each case was needed, with remedial treatment of the predisposing cause. The disease was curable and the patient must be encouraged to co-operate

in the treatment. Women who had felt degraded, when told that they were subjects of a disease plucked up courage and cherished the hope of cure. Unconditional abstinence was essential, and from one to two years were generally required. Mrs. L'Oste had found about 30 per cent. were permanently cured, the patients having belonged to the cultured and wealthy classes. —*Br. Med. Jour.*, April 6, 1889.

Delafield (F.) on the Treatment of Acute and Sub-Acute Nephritis.—In the very mild cases of nephritis, where the only symptoms are a diminution in the quantity of urine and the presence in it of albumen casts, and red and white blood cells, the only treatment needed is rest in bed and fluid diet. In the more severe cases there are added to the changes in the urine, fever, prostration, loss of appetite, nausea, vomiting, anæmia. In the still more severe cases there are also headache, delirium, stupor, convulsions, labored heart's action, hypertrophy of the left ventricle, a pulse of high tension, and dropsy. In the cases where the urine is suppressed for a number of days, the patients develop alternating stupor and delirium, and pass into the typhoid state. The regular duration of a fairly developed acute nephritis seems to be about four weeks. Its natural termination, with or without treatment, is in recovery. But the more severe cases may prove fatal, and it is often proper to interfere in order to secure greater comfort and safety for the patient. The indications for treatment are the nephritis itself and the contraction of the arteries which may be present. The first indication is met by means which relieve the congestion of the kidneys, heat to the entire skin, dry or wet cups or heat over the lumbar region. The second indication is met by the use of aconite, chloral hydrate, and opium, in small doses and at regular intervals, and the author recommends the following routine: Rest in bed; fluid diet; washing the entire skin clean every day; for two successive days drachm doses of sulphate of magnesia every hour until one ounce has been taken or the bowels begin to move; after this the tincture of aconite in doses of one minim, every hour. In a few days the albumen will be diminished, pulse soft, dropsy gone, but anæmia will be left. Milk is now gradually replaced by solid food and iron and oxygen given. The conditions requiring treatment in sub-acute nephritis are: 1. The sub-acute nephritis; 2. The changes in nutrition and in the composition of the blood; 3. The dropsy; 4. The conditions of the arteries; 5. The cerebral symptoms; 6. The acute exacerbations of the inflammation. For the first indication, residence in a warm climate and out-of-door life. If the patients remain in a cold climate it will be necessary to confine them to the house for much of the time. The second, the use of iron, oxygen, massage, and relief of constipation. The diet, except during acute exacerbations of the disease, should be as much solid food and fats as can be digested. The excessive use of milk and mineral waters is to be avoided. The regulation of the diet and the treatment of the anæmia often relieve the dropsy. The condition of the arteries and heart is to be watched throughout the disease. High arterial tension can be relieved by nitro-glycerine, chloral, or opium. Low arterial tension, theoretically by digitalis or ergot, but the author has found no advantage in doing this. The cerebral symptoms are avoided by watching the excretion of urea and the condition of the arteries. The quantity of urine should be large enough to make up for its diminished solid contents. High arterial tension is to be relieved at once. The acute exacerbations are treated in the same way as an attack of acute nephritis.—*Medical News*, March 16, 1889. W. V.

Evans (G. A.) on the Germicidal Treatment of Consumption. — Inasmuch as so many unsuccessful efforts have been made to discover a medicament or method of treatment that will destroy tubercle bacilli in the lungs of the phthisical, without damage to the patient, I am impelled to suggest that it might be more rational for us to transfer our efforts to the broader field of attempting the total annihilation of the germ as it exists in nature, for, as it seems to me, were it possible for any given medical man to devise a way or a means for the total destruction of the bacilli in any given consumptive's lungs, the germs would soon be replaced in his tissues from the atmosphere, which, we may feel certain, contains them in great numbers in the form of floating dust. It will be remembered that Miguel found 55,000 germs, embracing many varieties, in ten cubic metres of the air of the *rue de Rivoli*, Paris. Recent attempts to destroy tubercle

bacilli in the lungs of the phthisical by the respiration of air carried to a high temperature, as suggested by Wiegert, inspire this communication. We can not lose sight of the fact that a temperature considerably less than 300° F. is sufficient to coagulate the albuminoid elements of animal tissues, if brought to bear for only a few minutes. The high degree of humidity of the residual, reserve, and expiratory tidal volumes of air serves to protect the lungs and air-passages (and also the bacilli) from abnormal grades of temperature. The familiar illustration of plunging a wet hand into a vessel of molten metal exemplifies this. Many tubercle bacilli are found, when present in phthisical lungs, deeply imbedded in the tissues, and these tissues must be invulnerable to the influences brought to bear for the destruction of the germ; if otherwise, the result is obvious.

In conclusion, I wish to put on record the statement that no germicide will be found that will be able to destroy tubercle bacilli in the lungs without damage to the patient, and, further, that if this contention is ever shown to be wrong, our ability to destroy the parasite under such circumstances will be of no advantage to the phthisical.—*N. Y. Med. Jour.*, April 27, 1889.

OCCASIONAL REPORT ON DISEASES OF CHILDREN.

BY E. S. BROWN, M.D.

Holt (L. Emmet) on Cerebral Symptoms in the Pneumonia of Children.—Two points about pneumonia in children have been positively stated in almost every text-book of diseases of children. The first is that disturbances of the central nervous system are much more likely to be met with in young children than among adults; the second, that these are almost invariably associated with disease of the apex of the lung. As to the first point, the author's own experience abundantly confirms that of others. In regard to the second one, however, which has been denied by Eustace Smith, the writer has appealed to his clinical records with reference to nervous symptoms, and has carefully classified his points.

Dr. Holt's records presented for analysis one hundred and seventy-three cases, characterized as follows: seventy-three were lobar pneumonia, with two deaths; and one hundred, broncho-pneumonia, with a mortality of thirty-four. Thirty-four cases, or twenty per cent. of the whole number, presented decided cerebral symptoms, as convulsions, delirium, stupor, drowsiness, irritability, and excitement. Cerebral symptoms in pneumonia may depend upon complicating meningitis, or suppurative otitis media; but these causes are extremely rare.

Among the writer's cases, there were thirty-eight cases of pure apex-pneumonia: right, twenty-three; left, fifteen. Of these cases seven, or eighteen per cent., had cerebral symptoms. There were thirty-six cases of pure base pneumonia: right, thirteen; left, twenty-three. Of these cases four, or eleven per cent., had cerebral symptoms. In seventy-three cases there was extensive disease: both apices in two; both bases in four; and in the remainder, nearly the whole of one lung or large areas in both lungs were involved. Of these cases twenty, or twenty-seven per cent., had cerebral symptoms. In other words, in fifty-six per cent. of the thirty-four cases with cerebral symptoms the lesion was extensive.

The author then draws the following deductions:

I. Cerebral symptoms in the pneumonia of children are very common.

II. Convulsions belong almost without exception to infancy, being rarely met with after two years. Occurring at the outset, they belong essentially to lobar pneumonia; they do not indicate a bad prognosis, nor even, in most cases, a severe attack. When late convulsions come on, death within twenty-four hours may confidently be predicted.

III. Delirium comes oftenest between the ages of five and eight, usually in conjunction with extensive disease and high temperature. These cases, although severe, with but few exceptions recover.

IV. There is no such intimate association between cerebral symptoms and apex disease, as has been frequently stated. Such symptoms occur in only about one fifth of the apex cases.

V. Nervous symptoms occur much more frequently (one third of the cases) when the disease is extensive and the temperature very high.—*Med. Record*, April 7, 1888.

O'Dwyer (Joseph) on Atelectasis.—The author, in a long service at the

New York Foundling Asylum, has not seen a case of atelectasis on autopsy, where croup was the cause of death, which did not show evidence of beginning infiltration when submitted to the microscopical test. The most serious results of collapse of the lung are the interference with the interchange of gases, and the impediment offered to the circulation. Every collapsed lung is of necessity a congested lung. In the treatment of atelectasis it must be remembered that in the majority of cases the power to inflate the lungs exists, but is not used. In young children this latent power can be called into play by exciting some of the forcible expiratory efforts, such as crying, coughing, or sneezing. Crying is particularly efficacious, because the approximation of the vocal cords, by obstructing expiration, condenses the air, and at the same time prolongs the effort. The author states that the so-called hypostatic congestion of typhoid fever is probably always atelectasis to begin with, but that the power to keep the lungs inflated is almost always present, though not used unless the patient's attention be repeatedly called to it. In the asphyxia of the newborn, mouth to mouth inflation is easily performed, if the infant's nostrils are closed, and a moderate degree of pressure used at first, in order to prevent forcing the epiglottis down on the larynx. The writer has never yet failed to expand the lungs by this method, and has often succeeded in establishing normal respiration after continuing this process for upward of half an hour. Inflation by means of a catheter passed through the larynx is less effectual, because most of the air returns by the side of it. The author recommends an instrument of his own invention, designed to so tampon the larynx that any of the air passed through it would be prevented from returning. With this instrument inflation can be practised either by the mouth or by means of a rubber-bulb attachment. Experiments on the cadaver have shown how much air can be forced in with safety.—*N. Y. Med. Jour.*, March 9, 1889.

Clark (J. E.) on the Treatment of Incontinence of Urine in Children by the Sound.—In a practice of nearly forty years, the author has had a large number of cases of incontinence of urine in children, and he has used nearly all the drugs that have ever been suggested for this condition. It finally occurred to him that in many cases perhaps the trouble was due to a condition of irritable urethra, such as is present in the adult in cases of spermatorrhœa; and if so, that it could be cured in the same way, by the passage of the sound. Repeated examinations have proved the correctness of this view, and the author recommends the sound as the proper measure in all uncomplicated cases of incontinence of urine in children. He adds that he has never found any stricture, only a spasmodic resistance to the passage of the sound, sometimes called spasmodic stricture. The writer warns against dilating the urethra. He believes No. 9 English is as large as most children under twelve years of age can bear.—*Archives of Pediatrics*, March, 1889.

THERAPEUTICS.

Birch (E. A.) on the Use of Indian Hemp in the Treatment of Chronic Chloral and Chronic Opium Poisoning.—The first case was a man with the chloral habit who consulted the author for functional disturbance of the heart, insomnia, and mental depression.

His chloral was peremptorily stopped, and he was prescribed a pill containing half a grain of ext. cannabis ind. with a few grains of the compound colocynth pill, to be taken three times a day. The result was an *immediate* improvement. The craving for the chloral had almost vanished in twenty-four hours, natural sleep returned after a few days, and he began to enjoy his food.

The second case was a young Eurasian whom I found to be a most miserable object, aged about twenty-four years, yellow, intensely anæmic, and extremely emaciated —an "exhumed corpse" in fact, lying upon a couch, suffering acute agony in every limb. His liver and spleen were both materially enlarged. His history was shortly this. Occupying a position of considerable responsibility, and compelled to reside in one of the most desolate and depressing regions of Bengal, he became a confirmed and very excessive spirit drinker, till, fearing the consequences, he resolved to conquer the habit, and he did so most thoroughly, but with the frightful assistance of opium. Laudanum was the form selected, and for at all events four months prior to his coming under my notice he

admitted having consumed not less than two ounces daily. His friends, who had only just rescued him from his isolated position, were quite hopeless of the possibility of recovery. Here there was the well-known train of symptoms—insomnia, anorexia, disordered bowels, conscious delusions, though there was no confusion of ideas in conversation, and so forth. Again I resorted to cannabis, commencing with only a quarter of a grain of the extract, gradually increasing it to half a grain, one grain, and one grain and a half three times a day, with the happiest result. Ability to take food and retain it soon returned, and after a time an appetite appeared; he began to sleep well; his pulse, which could not be counted at first, exhibited some volume; flesh rapidly accumulated; and after three weeks he was able to take a turn upon the veranda with the aid of a stick. After the lapse of six weeks he spoke of returning to his post, and I never saw him again.

I have never before or since had such typical cases of this class to deal with, but I have lost no opportunity of testing the cannabis in the direction indicated as far as possible, and I am satisfied of its immense value. The chief point that struck me was the *immediate* action of the drug in appeasing the appetite for the chloral or opium, and in restoring the ability to appreciate food. It seems to supply the place of the poison, to stimulate the appetite, to increase the heart's power, and thus to procure sleep indirectly, as well as directly, by its own sedative effect. Moreover, I am convinced that it is a diuretic, and that this action helped in the above cases. I prescribed the cannabis simply with a view to utilizing a well-known remedy for insomnia, but it did much more than procure sleep. I think it will be found that there need be no fear of peremptorily withdrawing the deleterious drug if hemp be employed. I know that the mere withdrawal of chloral will effect a cure, but at the expense of an interval of suffering which need not be incurred; and the same in a different degree holds true of opium. Upon one point I would insist—the necessity of concealing the name of the remedial drug from the patient, lest in his endeavor to escape from one form of vice he should fall into another. Hence the prescription should be made as complex as possible, and at the earliest moment the dose of the extract should be diminished gradually till eventually it is withdrawn altogether from the prescription.—*Lancet*, March 30, 1889.

Mackenzie (S.) on the Treatment of Certain Cases of Chronic Uræmia by Morphine.—A woman, aged thirty-eight, had suffered from chronic diffuse nephritis of some years' standing. There were anasarca, ascites, and breathlessness. The urine contained from one half to two thirds of albumen. The heart was hypertrophied, and there was double papillo-retinitis. She was treated for the renal symptoms with great benefit, and in about six weeks was free from dropsy and breathlessness, and was able to leave her bed. One evening, after unusual exertion in the afternoon, she was suddenly attacked by intense dyspnœa, with respirations fifty in the minute. The heart's action was weak, 150 to 200 per minute; she was cyanosed, and covered from head to foot with clammy sweat. She was in a condition of mental excitement, with great terror of dying. She was treated with nitrite of amyl, alcohol, ammonia, and ether without any relief, and then one sixth of a grain of morphine hydrochlorate was injected hypodermically. In a few minutes the dyspnœa became less urgent; in twenty minutes the patient was able to lie down, and on the following morning was in her usual condition. Several subsequent attacks were treated in a similar manner after the failure of other remedies. Morphine hypodermically and internally never failed to afford relief, and at no time were toxic effects induced. The patient died three months and a half after the first attack of dyspnœa of symptoms of chronic Bright's disease. Case 2 was a woman, aged twenty-eight, suffering from granular kidneys of four years' standing. There was considerable anasarca, about one third albumen in the urine, hypertrophy of the left ventricle, with mitral incompetency, and double papillo-retinitis. She suffered much from breathlessness and headache. After decided improvement for a time, she suffered from severe headache, nausea, breathlessness, and irregular action of the heart, and great sleeplessness. Chloral, bromides, nitroglycerine, and inhalations of oil of juniper were used without effect, or with little effect. Liq. morphine hydrochlor., ℥x, was then administered with rapid alleviation of all the symptoms. It was repeated on many sub-

sequent occasions with equal benefit, and with no drawbacks. The patient died of the combined effects of a carbuncle and the renal disease about two months after the treatment was employed. Ten-minim doses of the solution of morphine always promptly relieved distressing symptoms; five-minin doses were not sufficient.—*Br. Med. Jour.*, April 13, 1889.

Northrup (W. P.) on a Case of Antipyrin Poisoning.—An hysterical woman of forty-four, a victim of hemicrania since childhood, took 15 grains of antipyrin with a half tablespoonful of whiskey upon an empty stomach. She felt no apprehension, no nervousness on taking the remedy, but took it rather with confidence that it would help her, if not wholly relieve her.

As soon as she had taken the dose she felt "queer," that "the medicine was going all through" her, was mounting to her head; she had sense of "smelling pepper," and she began to sneeze—sneezed fully a dozen times in rapid succession. This was followed by an urgent desire to defecate; she arose from her bed to get to the commode, and fell heavily upon the floor unconscious. The next remembrance was of a sharp pain from a hypodermatic injection of whiskey in her wrist and of some one bending over her urging her to drink from a glass.

The patient was lying on the bed, her eyes closed, her countenance pale leaden, her "jaw dropped"—in a condition of extreme general relaxation. There was no pulse at the wrist, no sensitiveness of conjunctiva, and no amount of irritation aroused her. I immediately injected 20 minims of whiskey into the first available place, and shortly repeated it. The second injection caused her to move her hand to avoid the pain. In a few moments more she opened her eyes with a wild staring look, and presently began to vomit frothy mucus. This "dry" retching continued more than an hour, at the end of which time the patient was nearly exhausted, though clear in her mind. Her headache was not relieved.

For a week she kept close to her room, feeling that for some reason the medicine had upset her digestion, and that her headache, though but little prolonged, had been more than usually agonizing.

At the end of a month my patient was quite recovered from her treatment, and was again suffering as usual from her periodic visitant. During this time she heard of numerous friends who had been relieved by the remedy—many ladies of her church who carried antipyrin in their purses, and during the long prayer, if headache threatened, slipped a capsule or powder or tablet into their mouths, and the attacks did not come on.

Even after her former experience, though I suspect she never fully realized how the antipyrin had affected her, she consented to try the remedy in one third the previous dose. I took the precaution to get the medicine from a reliable down-town drug firm, and directed that the tablet of five grains of antipyrin be taken on a full stomach, and *with* a tablespoonful of whiskey with water.

At the first symptoms of her next headache, the patient took her capsule and whiskey as directed, and only communicated the fact when she began again to "feel queer."

When the sister of the patient learned that the remedy had been taken, she hastened to me, and I arrived at the side of the victim of headaches within few moments.

She was lying on a sofa with her head raised, her face this time flushed a deep crimson, her neck, wrists, and hands covered with uticaria, tearing the clothing from her neck and chest, sighing and gasping for breath with a worried and anxious countenance—comparable only to the severe dyspnœa of Bright's disease.

The pulse at the wrist was rhythmic, moderately full, but without good tension. The urticaria developed its characteristic wheals rapidly over all the limbs of the patient, the irritation tormenting her and adding to the already existing extreme restlessness. After an hour the severity of the symptoms began to subside.

She has since continued to have periodic headaches. Her general health is good, and she wears constantly the glasses fitted during the course of treatment.—*Med. News*, April 27, 1889.

Bull (C. S.) on the Value of Electro-Therapeutics in Lesions of the Optic Nerve.—In optic neuritis from whatever cause, and in papillitis or choked disc from intracranial tumors, galvanism, whether direct through the closed lids and eyeball, or indirect through the cervical sympathetic, has no real value and should be abandoned.

In optic neuritis, due to heredity or con-

genital tendency, galvanization of the sympathetic nerve in the neck is of no value.

In simple, uncomplicated atrophy of the optic nerve, the use of the constant current cannot be said to promise either positive improvement or an arrest of the degenerative process. In most of the cases in which an improvement of vision has been noted, it proved to be merely temporary; and the same may be said of the apparent retardation of the degenerative process.

In cases of injury to the optic nerve, galvanism has not proved of the slightest permanent value.

In traumatic anæsthesia of the optic nerve and retina, uncomplicated by any laceration of nerve tissue or rupture of nerve fibres, galvanism carefully and persistently applied has been known to produce a rapid and permanent improvement of vision, when applied directly to the closed lids, and the current passed through the eyeball.—*N. Y. Med. Jour.*, April 27, 1889.

Robinson (B.) on the Toxic Effects of Wormwood.—Recently I was consulted by a gentleman who complained of vertigo, "weakness and trembling in his limbs,"—so much so that he had to discontinue his writing,"—of "a dragging pain" over the lower part of the abdomen, of a constant desire to micturate, and of a burning sensation at the tip of the penis. He volunteered the statement that, at about 8.30 A.M., after breakfasting, he took a quarter of a pint of a home-made infusion of wormwood. The above symptoms came on about an hour afterwards, and increased in intensity for about forty minutes, after which they gradually subsided. When I saw him at 10.30 A.M. the toxic effects were evidently passing off; so, save a little stimulant, if necessary, I considered treatment useless. Except for a slight feeling of weakness in the limbs, which lasted all day, by 2 P.M. he had entirely recovered.—*Lancet*, April 13, 1889.

Myrtle (J. A.) on Symptoms of Poisoning from the Use of Hydrochlorate of Cocaine.—Miss ——, aged forty-five years, came under my care on account of a severe attack of acute eczema. She was anæmic, very neurotic, of gouty habit, and had been for twenty-six years subject to neuralgia of the head and stomach; the gastralgia was most severe, the peculiar feature being that, for months, the only article in the way of food she could take was lump sugar, and of this she would consume from a half to three quarters of a pound daily. The eczema was most marked on the face, arms, and legs; as it began to yield she complained of intolerable itching in both eyes; the eczema had passed from the skin to the mucous membrane. To relieve this a three-per-cent. solution of cocaine hydrochlorate with ac. boric. (three per cent.) was prescribed, three drops (measured) being put into each eye night and morning. The result was most satisfactory, as far as the eyes went, but she complained that, immediately after the drops were applied, she felt a peculiar sense of numbness in the back of the tongue and throat, followed by intense palpitation, irregular action of the heart, disposition to faint, and extreme nausea, amounting almost to vomiting; she also had to unfasten her clothes, owing to the sudden and great distension of the stomach and bowels with flatulence. The symptoms lasted for hours after each application of the drops. She was seen the third day after this treatment was commenced, and the evil effect of the cocaine being recognized, the drops were discontinued, with the result that the disturbing cardiac and abdominal symptoms disappeared.

When we consider that not one eleventh of a grain of cocaine was dropped into each eye, and that not half that quantity would pass the lachrymal ducts into the throat, we cannot fail to recognize the power which this drug must possess over the cardiac and gastric nerves.—*Br. Med. Jour.*, April 6, 1889.

Armstrong (A. A.) on the Injurious Effects of Cocaine.—A prolonged use of cocaine was made in my own person, for the relief of a severe pressing pain, caused by an intra-nasal deformity, since entirely cured by removal of a portion of a turbinated bone by Dr. F. H. Bosworth. It was used for a year or more, in the form of spray, at different intervals.

Insomnia and loss of appetite were always present as long as any of the drug was in the system, but soon became normal on its suspension. The most noticeable reaction was in the nose itself, always in the form of increased hyperæmia, the more marked the shorter the interval between times of using it; slight if two weeks elapsed, but severe if used for several days in succession, even to the utter occlusion of the nares, so that no air could be forced through them. This would pass away in

twenty-four to forty-eight hours. But the worst effect is on the nervous system. I think it must be on account of the proximity to the brain, for I have injected it all over the body in scores of minor surgical operations, without ever noting the slightest untoward effect. I never experienced any delightful effects, though pain was always relieved for hours. On the contrary, a most extreme nervousness comes on, making one feel that he would do any thing to forget himself. (I remember one day, when not very busy, of reading the whole German grammar through at one sitting.) The pupils become dilated, and the face assumes a changed, weird expression. This, too, subsides as soon as the drug is out of the system.

I am convinced that the prolonged use of cocaine in the nasal cavities is pernicious, tending to defeat the very objects for which it is often used.—*Med. Record*, April 27, 1889.

The Rush after New Remedies.—The roseate hues which commonly tint accounts of the marvellous actions of new remedies in the early dawn of their discovery are not unfrequently disappointing when more closely criticised. They have too often an unpleasant fashion of fading away when robbed of the glamour of novelty and dragged into the prosaic daylight of routine. The natural tendency of those who have been tempted with delusive hopes is to keep a discreet silence over their failures, or to attribute their lack of success to an imperfect selection of appropriate test cases, or to some mysterious difference in the composition of the remedy employed when the original statements were made. It is so hopeless, as a rule, to attempt to prove a negative, that the failures of new remedies are to be gauged by silence rather than by direct statements. It is very rarely that comparative results of treatment are steadily accumulated and published to show the inefficacy of some much-vaunted system. Hence it is extremely difficult to arrive at satisfactory conclusions about many new drugs, of which the most that can be said is that they have been lauded, as was remarked in an article upon "Phenol in Enteric Fever" in our last issue, as "the greatest discovery of modern therapeutics." It is much to be desired that those who on good grounds have arrived at definite negative conclusions should collect and publish their observations to remove false impressions, and to save others from going through the same tedious and disappointing process. An old story represents a professor advising his pupils to be eager in their use of new remedies "while they still possess curative powers," and it is to be feared that there is but too much truth in the sarcasm. The tendency of modern therapeutics is to seek restlessly and continuously for some new thing, discarding as useless much that has stood the test of time. And for this the medical profession is not solely to blame. The craze for domestic medicine has been such that people who read their prescriptions frequently express lack of confidence in the skill of their adviser on finding that simple well known remedies have been ordered. The science of therapeutics necessarily knows no bounds, but as a science it certainly suffers from an accumulation of hasty observations and imperfectly digested facts.—*Lancet*, April 20, 1889.

SURGERY.

Mackenzie (G. H.) on a Case of Spontaneous Disappearance of Laryngeal Growths after Tracheotomy.—A boy aged about five years was brought to me at the Western Dispensary in April, 1883, on account of difficulty in breathing. This trouble dated from an attack of laryngitis during measles a few months previously. The obstruction was situated in the larynx, but its exact nature could not be determined with accuracy on account of the restlessness of the patient. Tracheotomy was necessary, and was performed by me on April 19th. The child recovered rapidly from the operation, and continued to wear the tube for about a year, during which time there was laryngoscopic evidence of the presence of inflammatory thickening and warty-looking growths about the glottis. Towards the latter part of this time these gradually disappeared, the vocal cords cleared up entirely, and the tube was permanently withdrawn.

It is now about six years since the operation was performed, and during the whole of that time there has been no indication of any tendency to recurrence of the growths. The voice is clear, the cords are healthy in color and outline, the breathing is normal, and the development of the boy is good.—*Lancet*, April 6, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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OCCASIONAL REPORT ON DISEASES OF THE SKIN.

BY CONDICT W. CUTLER, M.D.

Zeisler (J.) on Tuberculosis of the Skin.—From an ætiological standpoint, there may be included under the general term tuberculosis of the skin,—

1. Tuberculosis cutis vera.
2. Scrophuloderma.
3. Lupus vulgaris.
4. Tuberculosis by inoculation.
   - *a.* Verruca necrogenica.
   - *b.* Tuberculosis verrucosa cutis.
   - *c.* Tuberculosis papillomatosa cutis.
   - *d.* Tuberculous ulcerations.

Tuberculosis cutis vera is a rare affection, occurring only during the advanced stage of phthisis, and is soon followed by death. It always starts from one of the mucous outlets, and spreads to the neighboring skin.

It consists in isolated rounded or oval ulcers, granulating and shallow. The edges are slightly infiltrated. They are irregular and ragged, and by coalescence become serpiginous. They cause very little pain.

Scrophuloderma is far more common, and always associated with general symptoms of scrophulosis. These scrophuloderma ulcerations are the result of disintegration of tubercular glands or granulations formed beneath the skin.

At first a round or oval infiltration is formed in the subcutaneous tissues without pain, which becomes softer, and, attaching itself to the skin, gives that structure a thin, bluish, hyperæmic appearance.

A cold abscess thus forms, which soon breaks open, leaving flat, superficial ulcers of deep sinuous cavities, with undermined edges, and filled with soft, pale granulations which bleed easily and secrete a thin, yellowish pus. Crusts may form, under which pus collects in large quantities. The most common seat of these ulcers are about the neck and face.

Lupus vulgaris has long been considered a tubercular affection of the skin. This became more certain when Friedländer found giant-cells in lupus nodules, but it remained for Koch to demonstrate the presence of the bacilli, and to cultivate the microbe from them. Still a few points as to the nature of the disease have not been satisfactorily explained: First, the bacillus is found only in very small numbers in the lupus nodules, but abundantly in other skin tuberculosis. Second, that lupus is least abundant in those countries where phthisis is the most common; this is not so in other forms of tubercle of the skin. Third, lupus has never been produced artificially, although pure cultures from lupous tissues may produce tuberculosis.

Inoculated tuberculosis of the skin is essentially a local affection, occurring mostly on the hands of physicians, and while attributed by many to infection by ptomaines, is doubtless due to inoculation by tubercle bacilli.

Verruca necrogenica makes its appearance usually over a metacarpo-phalangeal joint as a small, red, flat nodule, which soon becomes pustular, and drying up

forms a crust which upon removal forms again. The lesion soon becomes warty, and upon pressure discharges pus. It grows to the size of a penny, or larger, which, healing, leaves a scar, and occasionally produces general tubercular infection.

Tuberculosis verrucosa cutis. It occurs on the backs of one or both hands, rarely on the palms or forearms. It resembles a group of inflamed warts, occurs in patches of round or oval shape, often becoming serpiginous by coalescence of several spots. The patches enlarge peripherally, and are surrounded by an erythematous band inside of which is a zone of small pustules. The centre is formed by a conglomeration of little papillomas covered with crusts, between which are pustules or fissures out of which pus can be squeezed. Retrogression takes place by healing in the centre, the resulting scar being smooth, showing the enlarged ends of blood-vessels as red points. The disease is a very slow one, lasting sometimes up to fifteen years. It has no tendency to ulcerate, the suppuration being due to the presence of staphylococci.

Tuberculosis papillomatosa cutis differs from the preceding in that excessive papillary excrescences form over the face, resembling the so-called framboesia.

Tubercular ulcerations are not confined to mucous outlets, but appear at any point of inoculation. These ulcers are small and atonic, and show giant cells and bacilli.—*North American Practitioner*, March, 1889.

Anderson (McCall) on Dermatitis Herpeteformis.—It is probably not so rare an affection as some suppose, seeing that it is apt to be mistaken for pemphigus, erythema multiforme, eczema, etc. The most prominent characters of the disease are these:

1. It has a great tendency to be polymorphous, occurring as it does in various forms, which run into, or succeed one another during the course of the illness; the lesions being erythematous, papular, vesicular, bullous, or pustular, and these may be combined in various ways. In a good many cases the mucous membranes are involved as well, especially that of the mouth and pharynx.

2. It appears in successive crops of eruption (generally more or less in groups or clusters) at irregular intervals, each setting in, as a rule, with some fever and constitutional disturbance.

3. It is accompanied, and often preceded, by intense irritation, burning, or smarting, which may be generalized, or limited to the seat of the lesions.

4. It may attack any part of the body, but seems to have a great tendency to commence on the extremities, especially the forearms. The abdomen, hips, and external aspects of the thighs are also often implicated, but any region may be invaded.

5. It is generally symmetrical.

6. Its course is variable, but it is apt to continue, on and off, for years, relapses being the rule, and the lesions often differing from those of the primary attack.

7. It is generally met with in adults, and in males much more frequently than in females. In the latter it often occurs in connection with pregnancy (herpes gestationis).

8. The general health is usually not much interfered with by it.

9. It is often very rebellious to treatment.

The principal forms of the disease are the erythematous, vesicular, bullous, pustular, and papular.—*Edinburgh Med. Jour.*, April, 1889.

Jackson (G. T.) on the Atrophic Hair-Fall of Joseph.—The atrophic hair-fall of Joseph is called in question by D. D. Samuel (*Virchow's Archiv*, vol. cxiv., part ii., p. 378), who says that it is very remarkable that the pronounced fall of the hair after section of the second nerve of the neck had never been noticed before by older experimenters than Joseph. Samuel has experimented for many years on birds, and has never seen the feathers fall even after excision of the entire axillary plexus. Of late he has been repeating Joseph's experiments upon cats, and has, like him, seen the hair fall out after two weeks. There was then an infiltration of the tissues about the wound, followed by the formation of abscesses. As soon as the inflammatory infiltration subsides, the hair began once more to grow, and was soon as vigorous as before. This same accident of abscess formation also occurred in Joseph's experiments. Some of Joseph's cats died of pyæmia or tuberculosis. This leads Samuel to regard the alopecia in all these cases as simply inflammatory defluvium capillorum. This sets aside the influence of the nerves in the production of the hair-fall, and

their action is further militated against by the fact of the rapid regeneration of the hair in animals that survive the operation long enough and recover from its effects.—*N. Y. Med. Jour.*, March 2, 1889.

Hutchinson (J.) on Crateriform Ulcer.—A form of the epithelioma of the face hitherto scarcely noticed by writers is best termed *crateriform ulcer*, from its peculiar appearance. It differs essentially from rodent ulcer, chiefly in its rapidity of growth and the formation of a bossy mass which becomes excavated. It does not recur when properly and thoroughly removed. Microscopically the tissue is epithelial cancer, and shows the peculiarity in always beginning in moles.—*The Med. Press*, Feb. 27, 1888.

White (J. C.) on Treatment of Scabies.—In treatment of scabies three active agents (a scattering shot) combined seem to act better than when used separately. The following prescription is the one most commonly used:

℞	Sulph. flor.		ʒ ii.
	B-napthol		ʒ i.
	Bals. Peru		
	Vaseline	āā	ʒ i.

M.

One third of this ointment is to be rubbed thoroughly into the skin for three consecutive nights, and washed off the following morning in soap and water. On the first night of the treatment all the clothes worn next to the skin must be thoroughly boiled before using again.—*The College and Clinical Record*, Apr., 1889.

Haslam (M. H.) on Horny Growths on the Skin.—The patient was a woman fifty-two years of age, and presented two horny growths on the skin. One had been growing for fifteen years, and was situated about two inches above the upper border of the clavicle; this the patient had been in the habit of cutting from time to time when it got in the way of her dress. The other grew from the right upper eyelid and was first noticed about one year ago. Both were extremely dense and about three quarters of an inch in length.—*Birmingham Med. Review*, April, 1889.

Anderson (McCall) on Ihle's Method of Treating Tinea Favosa.—The patient was a young man nineteen years of age, and had suffered from the disease for eleven years. The method of treatment, which was commenced on January 5, 1889, was as follows: All crusts were removed by the aid of poultices, and after the scalp was comparatively clean it was washed with potash soap, and Ihle's paste was thickly spread on, and the head covered with a linen cap. The paste is composed of: Resocin, 1 dr.; lanoline, vaseline, zinci oxid., pulv. amyli, aa 3 drs. Once a day the cap was removed and the head carefully washed, after which the paste was re-applied. On the day previous to his being shown to the society some of the hairs were removed from the scalp of the patient and were shown to contain many spores and mycelia. The specimens were shown to the society. The treatment had been carried on without interruption for eight weeks.—*Glasgow Med. Jour.*, April, 1889.

Napier (A.) on the Treatment of Alopecia Areata.—The patient, a young woman of twenty-six years, had suffered from the disease for sixteen years. For four years there was not a single hair on the head, and the eyelashes and eyebrows had been absent for ten years. The treatment consisted of tonics (chiefly iron and strychnine) internally, while locally a stimulating lotion, consisting of equal parts of carbolic acid, rectified spirit, glycerine and water, was rubbed in twice daily. Within the last few months nitrate of pilocarpine (¼ grain in pill at bedtime) has been given, with good effect. The hair is now growing fairly well over nearly the whole head; it is glossy, strong, and deeply pigmented, and remains in when it does grow. The eyebrows and eyelashes have reappeared.—*Glasgow Med. Jour.*, April, 1889.

MEDICINE.

Harkin (A.) on the Treatment of Acute Rheumatism.—My treatment is of the simplest kind; the application of a blister, four by three inches, for eight hours to the cardiac region, followed immediately by cotton-wool dressing, preceded if in plethoric patients by leeches in the pericardial region, or cupping at the back in the space between the inferior angle of the scapula and the spinal column; but bleeding is the exception, and this remedy often succeeds in removing all the special symptoms, whether subjective or objective, in the space of twenty-four or forty-eight hours.

I scarcely ever prescribe medicine of

any kind, but should the case be prolonged, I do not object to the use of opium, alkalies, or salicin, but I regulate them to their proper place, as adjuvants or handmaids in the treatment, after the cardiac safety has been assured through the use of appropriate remedies. I do not mean to convey, that by the use of this topical remedy I have succeeded in every case, or that it is entitled to the designation of a specific. I am cognizant of several failures in my own and in the practice of others; I have not always been able to abort the attack, when accompanied with skin disease, such as peliosis rheumatica, pemphigus, erythema multiforme, or the sequel of pregnancy, or when engrafted upon chronic valvular injury; but when successful, as it generally is, it effects a perfect cure, a complete recovery, for such an occasion as a single relapse is unknown in its history. I certainly have had three well marked cases of recurrence of the disease after complete convalescence, due to fresh exposure to cold and moisture, but no relapse while under treatment or without evident cause.—*Provinc. Med. Jour.*, May 1, 1889.

Phillips (W. A.) on a Case of Gonorrhœa with Purpura Rheumatica.—A milkman, aged 19, with a previous history of chronic gonorrhœa, has had an acute exacerbation since February 8th; also an efflorescence on lower extremities since February 26th; also pain and swelling of several joints, March 2d.

On examination, March 2d: penis œdematous; purulent discharge from urethra, containing gonococci; inguinal lymph-glands swollen, spindle-shaped. A symmetrically distributed efflorescence of anterior and inner aspect of leg, and inner aspect of thighs extending into gluteal regions; over left ankle, the most troublesome joint, skin thickly covered; also upper extremities present a limited number about the wrists; rest of body free. The great majority of the lesions macular, some slightly elevated, of definite, irregularly circular outlines; sizes varying from pin-head to one-cent piece in area; in color a deep bluish-red, not changing on pressure, a few of the larger elevated ones changing at their edges on pressure, the uniformly deep color of their greater extent remaining. One large macule annular, others with small papules marking their centres. Between the larger and elevated spots great numbers of the smaller macules, some brighter red, others of the more prevalent bluish-red. No evidence of itching. *Joints:* Ankles swollen, left more than right; similar symptoms on the part of wrists, also metacarpal joints of both hands; parts in neighborhood of affected joints œdematous. No fluctuation. Temperatue normal.

March 5th. Ankles free, knees swollen and painful, left more than right. Prepuce œdematous, anteriorly a large macule, posteriorly a nodular body size of pea. Temp. normal. Photographed.

March 12th. Sudden appearance of great numbers of wheals on lower extremities, varying in size from that of a pea to the area of a silver half-dollar; some bright red, not changing on pressure, other rose-red fading on pressure, others colorless. No itching. Temp. normal. Older efflorescence brown, yellow.

March 13th. Wheals had all vanished, leaving many fresh macules, largest of the size of a silver quarter. No change of symptoms had accompanied fresh outbreak. Exciting cause not determined. Joints nearly free. Patient states that he bled freely from a slight wound of right hand.

March 20th. Joints free; color of efflorescence varying from brown to yellow. Urethral discharge, mainly mucus, slight. Urine contains many triple phosphates.

The thoracic and abdominal organs were negative, also the mucous membranes, except the urethral. There was no previous history of rheumatism. The majority of the skin lesions were purely of a hemorrhagic nature. Some individual lesions were of the character of erythema nodosum. The fresh crop of March 12th was purpura urticans.—*Jour. Am. Med. Assn.*, May 4, 1889.

Hopkins (H. R.) on Cardiac Dilatation and its Treatment.—The author advises rest, massage, very moderate indulgence in tobacco, tea, and articles of diet predisposing to uremia. Sexual excesses should be forbidden, and the action of the skin should be improved by wearing flannel, and occasional Turkish baths. A change of residence to one of sufficient elevation to insure dry, bracing air is advisable. The author does not favor high altitudes, only as they are apt to ensure a more oxygenated air.

Of drugs he thinks the most of digitalis most applicable to those cases where the

urine is scanty. If under its use the urine becomes still more scanty, he advises its instant withdrawal. Of the recently advocated substitutes for digitalis he thinks spartein has the advantage of acting much quicker. For immediate relief of impending cardiac failure he relies on amyl nitrite, and nitro-glycerine, and for the painful dyspnœa morphia hypodermically.—*Med. Press*, West. N. Y., May, 1889.

Langhorne (T. G.) on a Case of Cough and Convulsions Due to Adherent Prepuce.—A boy of five had been under constant but ineffectual medical treatment for two years for a dry, hacking cough which was always worse at night and kept him awake several hours at night, coming on in paroxysms and often accompanied by convulsions.

The doctor was hastily called one night finding the child livid, with dilated pupils, gasping for breath, and in general convulsions. He was found to have an elongated, adherent, very tight prepuce. A few whiffs of chloroform were given and circumcision immediately performed. The cough and convulsions never returned.—*Lancet*, April 27, 1889.

Porcher (W. P.) on the Origin of Sputa in Subacute Cough.—In inflammations of the larynx, the nose and naso-pharynx are the principal sites to which treatment should be directed. These inflammations produce the sputa, and the sputa which descend produce the cough.

The well-known fact that almost all sensations in the throat are referred to the anterior part of the regio laryngo-trachealis, will account for the profound impression of patients that the secretion of sputum is entirely produced by the mucous membrane of the lungs and bronchi, whereas experience has taught us that most generally the pathological disturbances are situated in the choana or naso-pharynx, and the proofs of this are:

1st. Physiological, by exciting the parts with a probe, as in a case where a probe being passed into the naso-pharynx, the patient asserted that, for the first time, the seat of the pain had been reached—which she had previously located below the clavicle.

2d. Pathological, by the different causes which give rise to the cough, viz.: colds and inflammations of the naso-pharynx, which, in our opinion, rarely, if ever, originate in the larynx.

3d. By the results of local treatment to parts.

Hence we may conclude from this (and opinion generally supports us in the conclusion) that when a patient applies to us suffering from a cough, we need not administer the invariable cough mixtures containing nauseating doses of antimony, squills, ipecac, etc., but simply confine our treatment to the nose and naso-pharynx.—*North Carolina Med. Jour.*, April 1, 1889.

Jenkins (J. F.) on a Case of Acute Yellow Atrophy of the Liver.—A shoemaker, æt. 42, had been complaining of pain in the region of the liver and stomach for upwards of two weeks previous to calling a physician. The man was of temperate habits, and was not given to excess of any kind. Dr. Geo. Howell, who attended him during the last week of his illness, and with whom I was called in consultation, gave the following history of the case: Upon examination, the patient's pulse ranged between 50 and 60 until within a few hours of his death, when it exceeded 100 per minute. The skin was jaundiced. The temperature never exceeded 100° F., and within a few hours of his death it was natural. There was slight nausea, but during the last week of his illness the patient neither complained of pain in the region of the liver or stomach. The area of dulness over the liver rapidly decreased, so that its lower border could not be detected upon the most careful examination when the writer was called in consultation, which took place about seven hours previous to the death of the patient. At no time did he complain of headache, or pain in any portion of the head. There was a tendency to stupor during the last week of his sickness, but up to twenty-four hours of his death (which took place March 10, 1889,) he could easily be aroused, and would answer questions rationally. During the course of the night previous to his death the patient vomited up a pint or more of dark grumous blood, looking very much like that which is described as the black vomit of the yellow fever. The stupor then became more profound, the pupils of the eyes were largely dilated, there being marked oscillation of the eyeballs from within outwards, and taking place within a certain degree of regularity, averaging about ten times per minute, and continuing within a short period of his death.

A *post-mortem* examination was made by

Dr. Howell, in the presence of several physicians, about twenty hours after death. An incision was made, exposing to view the stomach, bowels, and liver, showing that the latter organ was from one third to one half its normal size. Its upper surface was pale in color, studded here and there with patches having the appearance of rhubarb in color. The fluid in the organ was darker and thicker than natural. No microscopical examination was made. The stomach and spleen apparently were in a healthy condition. The kidneys were slightly enlarged. A short distance from the entrance of the gall duct into the duodenum was found an old ulcer partially healed, and which appeared to have no significance relative to the disease of the liver.—*Jour. Am. Med. Assn.*, May 4, 1889.

[The peculiarity of this case seems to be the absence of early grave cerebral symptoms.—ED.]

Formad on Acute Yellow Atrophy of the Liver Occurring after Criminal Abortion.—In the evening the woman was happy and well; the next morning she was seized with some pains and died in two days deeply jaundiced. The autopsy was made twelve hours after death, and showed all the organs in a stage of advanced decomposition. The womb was badly lacerated. There was gangrenous endometritis, pyosalpynx, and severe peritonitis. The liver showed acute yellow atrophy, which had not reached an advanced stage. Under the microscope the cells were all degenerated, and there were abundant crystals of leucin and tyrosin.—*Univ. Med. Mag.*, March, 1889.

Purdy (C. W.) on the Treatment of Glycosuria.—The legitimate field of therapeutics in glycosuria becomes practically narrowed down to the treatment of its accompanying symptoms. Disordered digestion is so frequent in glycosuria as to constitute it an accompanying rule. Indeed, many of the milder cases owe their origin without doubt to this cause. The digestive and assimilative functions should therefore receive especial support through such agents as experience has taught us prove the most efficient. Among these may be mentioned, pepsin, and the vegetable bitters, and especially strychnia. The latter I have come to regard with increasing favor.

Constipation, so frequent an accompaniment of glycosuria, should be especially guarded against, as this condition reacts very markedly in enfeebling the digestive and assimilative powers. I have an especial preference for the natural alkaline purgative waters to meet such requirements, since they relieve the over-acid condition of the intestinal canal so common to the disease. Friedrichshall or Sprudel—or the salt made by the evaporation of the latter—given before breakfast, in hot water, seems especially appropriate. In middle-aged people inclined to stoutness and overeating, a course of purgation by either of these agents often proves highly beneficial.

The various nervous disturbances accompanying glycosuria are, on the whole, perhaps best met by the use of bromides, especially that of sodium or lithium. It is not uncommon to meet cases of glycosuria complicated by anæmia. When pronounced, this condition is frequently attended by œdema of the extremities, and under such circumstances the liberal use of iron and arsenic is attended by excellent results. The appearance of multiple boils is not uncommon in glycosuria patients; a complication generally considered ominous of approaching danger. I have seen a disappearance of this complication in two weeks under the use of quinine—8 to 10 grains daily—after having resisted other measures for nearly three months.

The most dangerous, and certainly the most rapidly fatal, of all the complications of glycosuria is that of Kussmaul's coma—sometimes called acetonæmia. Since the treatment of this complication has thus far proved so unsatisfactory, a knowledge of the conditions commonly leading thereto should be borne in mind, in order to guard the patient against it. Constipation, mental emotion, and fatigue seem especially to predispose to this complication, while a highly acid state of the urine often precedes it. I have repeatedly, in these cases, observed sudden death by coma to constitute the penalty of a hunting expedition, or long railway journey entailing unusual fatigue. If the early indications of approaching coma are observed, stimulants and hot baths should be resorted to without delay. It is believed that diabetic coma is brought about by some toxic agent in the blood, perhaps derived from alcoholic fermentation of glucose. Whether this be acetone, or some other agent, we are warranted by certain facts in believing that it is an acid nature, and, therefore,

large doses of alkalies seem the most appropriate remedies to employ. An ounce of tartrate or citrate of soda dissolved in a pint of water may be given three or four times a day. The intravenous injection of sodium carbonate, with chloride of sodium, is strongly advised if coma has already become established. Under the latter circumstances, however, recovery is extremely rare under any form of treatment. On the whole, then, promising results are only to be expected by attempts at warding off the attack through such measures as have already been suggested.

In the management of glycosuria, careful dieting greatly out-weighs all our other resources combined. This fact should be strongly impressed upon the patient from the beginning.—*Atlanta Med. and Surg. Jour.*, May, 1889.

Stringfield (C. P.), on a Case of Ascaris Lubricoides with Obscure Symptoms.—The notes of the following case were kindly furnished me by Dr. F. M. Stringfield: The patient, a female, aged 46 years, mother of four children, all living, has had a hacking cough, accompanied by emaciation, severe dyspeptic symptoms, hemorrhage, and severe nervous symptoms, for a number of years. At times constipated, at others discharging mucobloody fæcal matter, attended with much pain. Patient of marked melancholic disposition, at times almost of suicidal tendency. Very irritable and peevish, with a constant weary expression of countenance. The patient was thought to be suffering from phthisis and had been so treated for years. No remedies given would lessen cough or relieve gastric disturbance.

Finally the patient was given two 2-grain doses of santonin, six hours apart. On the following day a female ascaris was passed and on the fourth day a male worm was passed, and immediately improvement set in.—*North Amer. Practitioner*, May, 1889.

Johnson (W. S. D.) on the Treatment of Puerperal Eclampsia.—A woman in her second confinement was seized with premonitory symptoms with puerperal convulsions. Dr. Johnson gave a *teaspoonful* of Norwood's tincture of veratrum viride, and delivered a nearly dead child. About half an hour later the woman had another *teaspoonful* of the remedy. The pulse was watched and improved from a small frequent and easily compressed pulse to a full and soft pulse 54 to the minute. The patient made a good recovery.

In forty years' practice Dr. Johnson has had but five cases of puerperal eclampsia, and the smallest number of convulsions in the other cases was twenty-four, one never regaining consciousness after the first convulsion and dying in ten hours. —*St. Louis Med. and Surg. Jour.*, May, 1889.

Moynan (W. A.) on the Treatment of Criminal Lunatics in Spain.—Having myself experienced the novelty of a visit to a Spanish lunatic asylum about a year and a half ago, I can quite concur with the statement that "the treatment of mental disease in Spain has not emerged from the mediæval barbarism so realistically depicted in the last century by the pencil of Hogarth." The asylum which I visited was the "Hospital de los Locos," in Granada. The first thing that greeted one on entering was the sight of a decidedly suspicious-looking whip, to which were attached about five or six lashes; this lay in a very conspicuous position in the attendant's room at the entrance. I was not informed as to whether it was used as a means of discipline, but the appearance and position of the instrument were unpleasantly suggestive of the fact. On passing through the building, which was of the crudest and barest possible description (there being no furniture of any kind, with the exception of fixed benches round the walls), I found the majority of the patients consisted of apparently chronic dements and imbecile boys. Having visited both male and female quarters of the building, under the guidance of a male attendant, and finding that the patients were all of the same quiet-demented type, I asked our guide if there were any excited patients. After some difficulty in grasping what was meant, he conducted us to the portion of the building occupied by "dangerous" patients. There was only one occupant, and the ponderous bolts having been withdrawn, the door of his cell was opened and revealed him in an absolutely nude condition, his sole bedding consisting of a loose litter of straw, from which he uprose on our appearance, and came forth with an inane smile to shake hands. On his emerging from the straw, I noticed that he had a pair of iron anklets securely riveted on his ankles behind, and attached to each anklet was an iron ring, through which a heavy

bar of iron (knobbed at each end for security) passed; so that in endeavoring to walk, he could not move one foot more than six inches in front of the other, and that with difficulty. I have no doubt the man may have had occasional periods of excitement, but, as far as I could see, he appeared to be a very harmless dement. In any case, none but a semi-barbarous nation in the matter of treating lunatics would resort to such a means of restraint. As regards the exposure to cold and weather, I was not able to judge, as it was during the hot season I paid my visit; but there did not appear to be any protection against wind or rain in any of the windows, and I daresay that this condition of things remained during the winter. The spiked bars to the windows, mentioned by Dr. Escuder, were conspicuous.—*Br. Med. Jour.*, April 20, 1889.

On Certain Effects of Tobacco Smoking.—Dr. A. G. Auld of Glasgow, thinks that tobacco is responsible for a variety of functional derangements which there is no reason to aver cannot terminate in organic disease.

He is convinced that the slightest trace of albumen in the urine is pathological, and that it is frequently induced by preventable causes, and one of these is chronic poisoning by nicotine. He thinks he has certainly traced the disorder in a few cases entirely, and in others partially, to the habit in question.

Another derangement consists in localized fibrillary twitchings,[1] something similar to what is observed in progressive muscular atrophy, and perfectly distinct from tremor. The twitchings are often excessive, and occur most frequently about the trunk and upper arms.—*Lancet*, April 20, 1889.

Shaw (A. B.) on a Case of Infantile Tetanus Successfully Treated by Large Doses of Chloral Hydrate and Bromide of Potassium.—Sixty hours after birth, and about forty-eight hours after treatment was instituted, about sixty grains of chloral hydrate and probably 150 grains of bromide of potassium had been given, by the rectum, fully nine tenths of which was retained, the masseter muscles relaxed, and the tetanoid seizures became so slight that the interval between doses was lengthened to three hours, at which interval they had to be continued for forty-eight hours longer, when the tetanoid seizures ceased. About eighteen hours after the enemas were discontinued, the nurse succeeded for the first time in getting the infant to swallow.—*St. Louis Med. and Surg. Jour.*, May, 1889.

Rouse (J. D.) on Malformation of the Umbilical Cord.—The child and placenta were simultaneously delivered. It was necessary to collect and hold the placenta so as to be able to find the extent of attachment of the cord, which was three inches in diameter and one and three fourths inches long, covering nearly all of the abdominal space. The intestines could be seen through the membranous covering, and on opening the cord all the intestines and liver were found in it. The child lived fifteen minutes.—*Cincin. Lancet-Clinic*, May 4, 1889.

SURGERY.

Dock (G.) on Two Cases of Rupture of Malarial Spleen from Traumatism.—Case I. Man, æt. 23. But little could be learned as to his previous history, except that he had recently suffered severely from chills and fever. A few days after arriving in Galveston, while working on a dredging tug arranging some tackle, he fell from the tug into a scow, striking with his breast on the side of the scow. He then arose, arranged the tackle as he wished, and got back on the tug. In answer to a question, he said he "had hurt his stomach." He then attempted to pick up a line, but failed, saying he was blind. He staggered and was helped into his room, but was so weak that he could not be assisted into his bunk, and asked to be moved outside. There he was placed on a mattress and pillow, given a dose of Jamaica ginger, and his abdomen rubbed with kerosene oil. Ten minutes later his face became pale, hands and feet cold, and he frothed at the mouth. He was taken into another room, and "several men were put to work on him." Mustard plasters were put on his abdomen and wrists. Five minutes later he died, being about twenty minutes after the fall.

I made the autopsy six hours after death:

Body of a man of middle size, of strong

[1] The twitchings here referred to are undoubtedly of the nature of a myoclonus.—Ed.

frame, and with well-developed muscles and panniculus. Skin quite bloodless, and of a dirty yellow tint, which was also evident in the scleræ, and the visible mucous membranes. There were no marks of violence on the body. The abdomen was slightly distended, and gave a dull percussion note over the lower part. On opening it, thin, dark blood poured out, and was removed to the amount of three quarts. Soft, dark clots, amounting to three pints more, were removed from the left side, partly surrounding and adhering to the spleen. That organ was fastened to the diaphragm by easily loosened fibrinous bands. On exposing it carefully it was found of the usual shape, but much enlarged, measuring twenty centimetres in length, thirteen centimetres in greatest width, and eight centimetres in thickness at the upper end. The capsule was thickened. At the junction of the middle and lower thirds, and corresponding to the margin of the ribs, was a rupture, extending clear through to the hilum. In the upper piece thus formed was an irregular, ragged tear, running five centimetres up on the external surface, and about two centimetres deep at the lower part. The splenic tissue was soft and bloodless, of a dark slate-green color; the Malpighian bodies prominent. The thoracic and other abdominal organs presented no gross pathological changes, except almost total absence of blood and a more or less marked greenish tint. Microscopic examination showed excessive pigmentation of the spleen and liver, and the same, not so marked, in the kidneys. The splenic enlargement was due to increase of the pulp.

Case II.—Male, æt. 35. Came down from a malarial locality in the interior of Texas to recover from ague, Galveston being free from malaria. Soon after his arrival he walked off a wharf in the dark, falling six or seven feet, and striking the sand heavily with his feet. Soon catching up with his companions, he made a jesting remark about his mishap. A few minutes later he cried out that he was blind, fell, and was taken up unconscious, and died rather more than an hour later.

Post-mortem examination, eighteen hours after death:

Body of well-nourished man of large frame. Skin anæmic and sallow, otherwise nothing abnormal on inspection. On cutting down to the peritoneum blood was seen, and a quantity approximating three quarts removed. It was nearly all fluid, and dark colored. Spleen of long oval form, weighing one-and-three-quarter pounds and measuring twenty-three by ten by five centimetres. Capsule flabby, but smooth. Beginning about the middle of the outer surface was a laceration running around over the anterior border to the hilum, and involving little more than the capsule. Near the lower end was another tear, running across the external surface seven centimetres, then seven centimetres more to the hilum, gradually increasing to a depth of one-and-five-tenths centimetres, and crossing the hilum without involving the root. Where the laceration involved the capsule only, this had retracted so as to expose the splenic tissue, as much, in some places, as one centimetre in width. The spleen tissue was soft, but not at all diffluent, dark, and bloodless; the Malpighian bodies enlarged. The other organs showed no structural alterations. Microscopically the spleen showed an increase of the fibrous tissue, as well as the parenchyma. It, as well as the liver and kidneys, contained melanotic pigment.—*University Med. Mag.*, May, 1889.

Keen (W. W.) on Uncompleted Nephrectomy; Calcareous Vessel Mistaken for a Calculus by the Needle Test, etc., etc.—A man of sixty-eight gave the following history: For over two years he had occasional attacks of renal colic, with almost constant hematuria and a sensation of heat in the right lumbar region. He had lost appetite and strength. In January, 1888, he had pleuro-pneumonia and septicæmia with phlegmasia of both legs. There was neither now nor at any other time any pus in the urine, nor were any calculi ever passed. After this illness he had, in forty-five days nine attacks of hematuria. On examination the urine was found to contain some red-blood disks and considerable granular, fatty material, and the region of the right kidney was found tender.

An operation was decided on and performed on November 3, 1888. Passing over the minor details of the operation, the author says:

"The finger detected a rather sharp irregularity deep in the substance of the kidney. The moment it was pressed on we were convinced that it was a stone. A needle was then passed into the kidney,

and the point of it grated with great distinctness against the supposed stone. The kidney was now seized with a volsella, and was loosened from the surrounding tissues in order to obtain freer access to it. This was followed by two results: First, very abundant, indeed, very alarming hemorrhage, from large veins that were so concealed under the last rib that they were seized with great difficulty, even after the rib was well raised, and when seized they were so friable that the ligatures would not hold.

"The second result of this operation was to disclose the fact that while the small portion of the kidney first discovered was normal, the rest of it was irregular, nodular, and friable, and evidently the seat of a malignant growth. Accordingly, I determined to remove the kidney, if possible. It was rapidly detached from its capsule by the finger, but it was so anchored internally at the hilum that it could not be brought to the surface, in spite of the fact that I got my entire hand into the cavity of the capsule."

All attempts at removal were finally given up, and the wound was packed with sublimate gauze.

The patient survived the operation three and a half hours.

An autopsy revealed the fact that any attempt to remove the organ, which was cancerous, would have resulted disastrously.

"Examination of the kidney after death showed us that no stone existed, but that what was felt by the point of the needle was either a calcareous vessel or a calcareous degenerative mass against which the point of the needle grated. It gave precisely the same sensation as a stone would have done. This possible error seems to me very unusual."—*Maryland Med. Jour.*, April 20, 1889.

Maddin (J. W., Jr.) on Amputation of the Thigh of a Three-Days'-Old Girl.—On Monday, March 11th, I was called to see a baby which had just been delivered by a midwife, the child of German parents; the father, a vigorous, healthy man, a cooper by trade, and the mother, a large muscular woman, weighing about two hundred and twenty-five pounds. Upon examining the child it was found that the right leg had been the seat of mortification, or dry gangrene, up to about the junction of the middle with the upper third of the thigh. From the knee down, the bones were bare of any covering, the foot was disarticulated from the leg, and seemed to be undeveloped, swarthy, mummified tissue. It was connected to the leg only by a few shreds of mortifying tissue.

At the end of three days there was an indistinct line of separation of the healthy from the gangrenous tissue, and the operation was resorted to immediately. The transfixion operation was the one selected, and was performed just below the hip-joint, making use of the anterior and posterior flaps, and it was with difficulty that enough healthy tissue to cover the wound was obtainable, so far up the thigh had the gangrene extended.

No tourniquet was used, but the bleeding was controlled by compressing the artery, where it passes over the pelvic bones, with the finger. The tissues were dissected back to within about an inch of the head of the femur, and the bone sawed into at this point. The operation was completed in the usual way, tying the arteries with silk ligatures and closing the wound by bringing the flaps together with silk sutures. No drainage was provided for, other than that caused by allowing the ligatures to pass out of the lower end of the wound. The wound healed very promptly, with but little suppuration or discharge; the dressings were renewed every two days, and at this writing, twenty days since the operation, there is only a small part of the wound not closed.

Ether was the anæsthetic used in this case, a very remarkable fact in connection with the anæsthetic being that nearly a half pound of ether was used before sufficient anæsthesia was accomplished to proceed with the operation, and it required thirty minutes to accomplish this amount of anæsthesia.

The child rallied from the ether and the shock very promptly, and has had no bad symptoms since, except occasionally to refuse to take the breast, during which time it was nourished by breast-milk taken from a spoon.

At the present time the child presents every prospect of recovery, although at the time of the operation it was hardly hoped that a favorable result could be accomplished.

The only cause which I could assign for the condition of the leg at the time of its birth was the wrapping of the cord around the limb in the early months of intra-uterine

life, or else to a fall which the mother sustained on Christmas day, being just eighty days before delivery. In this fall she struck the abdomen very forcibly on the ground.

This case is unique in the extreme early age (three days) at which the operation was performed (the child being only three days old), and in the fact that it required nearly a half pound of ether and thirty minutes of time to produce anæsthesia, which was never profound at any time.—*Med. Record*, April 27, 1889.

Stephens (T. G.) on Permanent Cure of Hydrocele.—A middle-aged German had a hydrocele, which I tapped, leaving the patient in charge of the steward, intending to return in a few minutes and remove the canula, but forgot it. The next day, on my return to the Infirmary, the steward asked me how long I was going to let that tube stay in that fellow's scrotum, as it was paining him very much; I told him that I thought it had been in long enough, and on examining him I found the serum thoroughly evacuated, his scrotum swollen and feverish. I withdrew the canula and gave him some general treatment, and a permanent cure was the result.—*Times and Register*, May 4, 1889.

Richardson (M. H.) on a Successful Case of Cholecystotomy, for Empyema of the Gall-Bladder and Removal of Calculi.—So far as he was able to find, this was the first successful case of the kind reported from New England, among one hundred and fifteen cases collected from the medical literature since the first operation in 1867, by Bobbs, an American surgeon. The first predetermined cholecystotomy was performed by Marion Sims on the 18th of April, 1878, but unfortunately with a fatal result.

The patient was sent to the hospital by Dr. Titcomb, of Concord, Mass., with a correct diagnosis. This fact was not known till after the operation.

A married woman, æt. forty, entered the hospital.

August 28, 1888. Patient had had fairly good health; seven children. Has had pain in right side for eleven years. Three years ago had pain more severe, and perceived a bunch the size of an egg just under the ribs on the right side.

Four weeks ago had attack of pain in left side with epigastric tenderness and pain. Difficulty in taking a long breath; chilliness. No pain over seat of tumor. Thinks she was very yellow during the attack. Bowels constipated usually. Micturition frequent and painful.

She is a large, strong, and healthy-looking woman. In the right hypochondrium, extending down into the lumbar region, there was a smooth, movable tumor about the size of a cocoa-nut; spherical in shape; hard and elastic. Tumor was easily displaced and moved freely with respiration. Its position suggested kidney tumor, though rather too high. The tumor was flat on percussion and no fluctuation could be made out. Examination of urine negative. Vaginal examination also negative. General condition good. No constitutional disturbance. No jaundice.

September 3d. Incision made in right linea semilunaris. Tumor found to be connected with liver, and probably a dilated and inflamed gall-bladder. Aspiration resulted in the withdrawal of a quart of purulent fluid, light yellow in color. The cyst was withdrawn from the abdominal cavity, and the greater portion cut off by means of the actual cautery. This brought the base of the tumor well within reach of the finger.

Five gall-stones a quarter of an inch in diameter were found in the bladder, a sixth could be felt impacted in the duct. This was squeezed back into the gall-bladder with the fingers placed outside the duct. A seventh could be felt, and this was slipped aloug in the other direction and gave no further trouble. It was probably forced into the common duct and into the duodenum. The remaining portion of the bladder wall I stitched to the edges of the abdominal wound, making a very satisfactory joint. The patient made a rapid recovery. The temperature went to 100° the evening of that day. Discharged well November 1st.

Strict antiseptic precautions, a solutio n of corrosive sublimate being used.

It is difficult to understand why there was little or no discharge from the gall-bladder. The most probable explanation is that the cystic duct was closed completely till the operation. The dilatation of the gall-bladder was caused by the secretions of the isolated bladder-wall. At the operation the cystic duct was cleared of the obstructing stones and through the patent canal the subsequent secretions escaped.—*Boston Med. and Surg. Jour.*, April 25, 1889.

Tomes (C.) On Epithelioma Arising in the Socket of a Tooth.—A second upper molar, of which the palatine root was detached from the two buccal, had been treated by the insertion of screws into their pulp canals, and a contour filling surmounted. When seen by Mr. Tomes it had been fairly serviceable for eighteen months, and the patient only complained that it was rather loose, but as there were ugly granulations surrounding the neck of the tooth, Mr. Tomes removed it. The following day the socket was filled with granulations which had very much the appearance of epithelioma, and several surgeons who saw the case were of the same opinion. Chloride of zinc paste was applied, being retained in position, and the neighboring parts protected by a small vulcanite plate. The result of a second application not being satisfactory, an operation was advised, and was performed three months later by Sir Joseph Lister, the disease having then spread backwards over the tuberosity and to the cheek. A large portion of the upper maxilla, including the tuberosity, was gouged away, the antrum being opened and the indurated portion of the cheek removed. Three years have now elapsed and there is no recurrence. It is an interesting point as to whether the epithelioma was due to the irritation of the root caused by its treatment, as we know of no similar case. Mr. Tomes is certain that the disease originated in the socket of the tooth, and not in the antrum, which, indeed, was at no time affected.—*Lancet*, April 20, 1889.

Thornton (J. K.) On Twenty-five Cases of Nephrectomy by Abdominal Section.—Eight of the cases had already been brought before the International Medical Congress in Copenhagen, and these were marked off from the seventeen unpublished cases in the table, and but briefly, if at all, referred to in the context. Of one of them, No. 6, which was reported a failure in 1884, with pain in the bladder and the other kidney, a very satisfactory subsequent history was now given, the patient being in perfect health, married, and mother of a son. There were twenty recoveries and five deaths in the series, a result 20 per cent. better than that generally given for all nephrectomies, including those by lumbar section. This result was compared with that in ovariotomy eleven years ago, the mortality being then much higher for this comparatively simple operation. Two of the fatal cases were pointed to as not properly to be counted against abdominal nephrectomy, one being a malignant tumor which had perforated the right pleura, and the other having died of hemiplegia, which was brought on by the anæsthesia rather than by the operation. All the features of special interest in both the successful and fatal cases were touched upon. The superiority of nephrectomy over nephrotomy and drainage for the cure of hydronephrosis was illustrated by six cases. Incision of suppurating kidney as a preliminary to nephrectomy was condemned. Tne author's practice of pinning out the ureter had led to no troubles, and was claimed as the chief factor in success. The removal of suppurating kidneys without any puncture during operation was strongly advocated whenever their size admitted it. The superiority of Langenbuch's incision was insisted upon. —*Brit. Med. Jour.*, April 13, 1889.

Earle (S. T.) on a Case of Blind Fistula in Ano Treated Unsuccessfully by Electrolysis.—The case was one that resulted from a case of ischio-rectal abscess that I opened freely November 19, 1888. After it had been opened kept it well drained, and from time to time kept up gentle stimulation of the abscess cavity by the passage of probes twice each week; then by injection of a strong solution of carbolic acid given at the same intervals to promote healing. These efforts were continued until December 31st, when the cavity had been apparently reduced to a narrow fistulous passage, but at that point it remained for several weeks without any appreciable improvement, when I decided to try the effect of electrolysis to promote healing of the fictitious track. I commenced with the use of the negative electrode in the sinus, using from 30 to 50 milliampères for ten minutes, at intervals of a week, and continued in this way for three weeks, after which I used the positive pole in the sinus with about the same strength of current for two weeks more. At the end of this time, finding no appreciable improvement, I discontinued its use, and with a sharp-pointed bistoury made a complete fistula of it, cutting through the intervening tissue, and left it to heal as an open wound by granulation.—*Maryland Med. Jour.*, March 16, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLE.

Souchon (E.) on the Drilling of Capillary Holes Through the Skull for the Purpose of Exploring with the Hypodermic Needle.[1]—Fully impressed with the importance of early diagnoses in cases of brain trouble, it occurred to me that it would be possible to substitute for the apparently formidable application of the trepan the simpler, readier, less formidable, and less dangerous procedure of drilling through the skull a small hole, only large enough to introduce a hypodermic needle.

With this idea in view I proceeded to test the idea practically on dogs. All the rules of strict antisepsis and of location of the spots for operation which have to be observed for trephining were followed here and strictly adhered to. The animals were placed under chloroform specially with the view of controlling them and keeping them perfectly quiet.

The spot to be explored was shaved of its hair by a clip of the point of the scissors, and the place well washed and rendered antiseptic. Then with a sharp-pointed aseptic bistoury a hole was made through the soft parts of the scalp. Through this the bit of a watchmaker's drill was introduced, and as soon as it had reached the bone the instrument was held firmly pressed against the bone, and the sliding knot of the instrument worked, at first slowly, then swiftly, and again slowly, as the bit penetrated the bone and came near the brain substance. The bit is provided with a movable screw, which is adjusted so as to prevent the bit from penetrating too deeply into the brain tissue.

As soon as the skull has been penetrated the drill is withdrawn and a hypodermic needle with syringe introduced. The needle should be *twice as large* as the ordinary needle of our cases, so that if it should strike the thick pus of an abscess, or the thick fluid of a cyst, the calibre will be large enough to suck it, which it will surely not do if the needle is as fine as the one ordinarily used for a hypodermic injection.

This procedure was performed twice on each side of the middle line of the skull on two dogs. Each time the needle was driven to the hilt within the tissues, the distance from the point to the hilt being about an inch and a half. The dogs were afterwards left to themselves.

Both recovered rapidly from the effects of the chloroform, and behaved as naturally afterwards as if their skull and brain had not been perforated four times at different places.

After a rest of two weeks the animals were again put under chloroform, and again the skull and brain were drilled and explored in four places.

The result was exactly the same as at the first sitting. They recovered rapidly. The dogs were kept about the yard for several weeks to see if any remote effects would develop, but none were noticed.

[1] Read before the Louisiana State Medical Society.

After the dogs had been driven away, they returned several times, and never showed any thing unusual.

During an experiment one dog was killed before recovering from the chloroform, to see what damage, if any, had been produced. Besides an extravasation of blood of the size of a nickel under the scalp, and one the size of a pea under the pia-mater, nothing else could be seen of the traumatism inflicted.

The greatest advantage of the method is the simplicity of the operation, and on that account the possibility of exploring several points of the brain at the same sitting, instead of being limited to a given area, as in the case of the trephine.

The needle, upon striking a tumor of greater consistency than the brain substance, would immediately impart the sensation, localization, and consistency to the hand of the explorer. If no such sensation is experienced, then the piston should be worked at different depths to see if there is no fluid tumor at the points explored.

Only in cases of tumors of the same consistency as the brain substance would the procedure be useless and yield no information, positive or negative.

I do not think, in the presence of the great progress of brain surgery, that it is a chimerical idea to say that some day the skull will be drilled in cases of cerebral hemorrhage, and the blood aspirated here as it is in other situations.—*New Orleans Med. and Surg. Jour.*, May, 1889.

OCCASIONAL REPORT ON OBSTETRICS.

BY ELIZABETH STOW BROWN, M.D.

Pershing (H. T.) on Pelvic Measurements and their Importance in Obstetric Practice.—This study of pelvic measurements seems to have been drawn out by the recent revival of the Cæsarean section. The one thing that the advocates of the improved operation most earnestly insist upon is that it be deliberately chosen beforehand, and that no attempt be made to deliver in any other way. The choice of so serious an operation implies a careful examination of the pelvis before labor begins or as soon after as possible. As a matter of fact, skilful obstetricians have attended women in confinement, with no apprehension of the case being an unusual one, have tried forceps, turning, and craniotomy in succession, and after the death of the patient have regretted that Cæsarean section was not resorted to in the beginning. It cannot be doubted that in many such cases a correct or even approximately correct knowledge of the pelvis would often lead to better treatment.

In order to form an independent opinion as to the value of such measurements as can be taken during life, the author has recently made careful measurements of ninety dried pelves, found in the various museums of Philadelphia. In this number are included twenty plaster casts made by Tramond, of Paris.

The author then discusses the history of pelvic measurements, method of taking these measurements, and the deductions to be drawn from the results. He enters into the full detail of the subject, and presents it in its complete aspect.—*Am. Jour. Med. Sci.*, Feb., 1889.

Napier (A. D. L.) on the Treatment of Puerperal Pyrexia.—The author remarks that the successful treatment of puerperal pyrexia depends not only on a recognition of the form or variety of the febrile attack, but also on a fair comprehension of the individual case. Some of the well-known causes mentioned are mental emotion, retention of clots, and traumatism with sepsis. The general indications for treatment invariably present are:

I. To relieve pain and procure rest.
II. To reduce pulse and temperature.
III. To maintain strength.
IV. To control urgent symptoms.

The author mentions as means of reducing pulse and temperature only those remedies which he can personally vouch for. Quinine stands first in his estimation, given by the mouth in hyperpyrexia in doses gr. x. to gr. xv. in the morning, and gr. xx. to gr. xxx. at night. The writer has ordered gr. x. every three or four hours, giving in some cases one hundred grains in twenty-four hours. In some cases vomiting after several doses has proved a troublesome complication. Quinine is recommended hypodermatically when rejected by the stomach. The hypobromate is soluble in 1 to 16 of water. It is necessary to inject 3 i. to 3 ii. at least thrice daily. The bulk of the injection is objectionable. Quinine in rectal suppositories of gr. xv. to

gr. xxv. the author has also used. Warburg's tincture, and aconite, antipyrine, kairin, salicin, and salicylate of sodium, carbolic acid in doses of ℥iii. in glycerine or mucilage, sulpho-carbolate of sodium, and benzoate of ammonium complete the list of antipyretic drugs that the writer has used in his experience as Physician-Accoucheur to St. Pancras and Northern Dispensary in London. Certain other measures are recommended as aids in appropriate circumstances, as venesection, vascular sedatives, and alcohol. The author approves of the wet pack as the most powerful means of abstracting heat in hyperpyrexia.—*The Practitioner*, March, 1889.

Jaggard (W. W.) on the Prevention of Puerperal Fever.—The principles upon which the prevention of puerperal fever depends are few and very simple. As summarized by Crédé, there are only two; they are: (1) prevent, as far as possible, lesions of the genital tract; (2) prevent the infection of the lesions that are inevitable. The extent of the necessary puerperal wound includes the entire area of the endometrium that contributes to the formation of the decidua; the neck of the uterus, particularly the os externum; the vagina, denuded to some degree of its epithelium by the friction of the passage of the child. The puerperal wound, thus marked out, cannot be prevented, but its limitation to these boundaries can be secured, in the large majority of normal cases, by attention to the following precautions:

1. Let the diagnosis of presentation and position, and of the stage of labor be made, as far as possible, by the methods of physical examination of the abdomen. Limit to the minimum the number of examinations *per vaginam*.

2. Let the bag of waters rupture spontaneously. The intact state of the bag of membranes must be preserved for at least two reasons: to secure perfect dilatation of the cervix uteri, and to prevent the access of air and other carriers of infection to the cavum uteri.

3. Preserve the perineum and vulvar orifice. If a laceration does occur, or if episiotomy is done, unite the rent in the one case, or the incision in the other, immediately on the conclusion of labor.

4. Refrain from digital dilatation of the cervix and exhibition of ergot.

5. Deliver the placenta by Crédé's method.

The second principle by which puerperal fever may be prevented is to prevent the infection of the lesions which are inevitable. This infection the author considers may occur in one of two ways: contact infection and indirect infection, or so-called self-infection. The surgeon sterilizes the field of operation, the immediate environment, and every thing that comes in contact with the wound, and the obstetrician acts under the same principles. The sterilization of the hands, instruments, appliances, and napkins, and the parts of the parturient woman are of course insisted upon. The author recommends during the first two days of the puerperium gentle friction of the fundus uteri twice daily, to aid in securing firm contraction and retraction, a practice which originated in Carl Braun's clinic.—*Jour. Amer. Med. Ass'n*, March 2, 1889.

Kingman (R. A.) on a Case of Pernicious Vomiting of Pregnancy, Resulting Fatally.—The case was interesting and instructive in many ways aside from its termination. There were certain features which were at least suggestive in connection with the study of causation. There was a sensitive and dyspeptic stomach; the presence of a rheumatic diathesis; a strongly compressed waist, which may have interfered with the function of the liver; a uterus strongly anteflexed; cervix eroded, and flattened against the floor of the pelvis; small and sensitive internal os; probable endometritis; sensitive and painful ovaries, both probably diseased and adherent.

Temporary relief was experienced after applications to the eroded cervix; temporary and very marked relief resulted from straightening and lifting the distorted uterus; benefit was obtained from warm and soothing applications, poultices, and douches; the patient felt better after the bowels were thoroughly evacuated; stretching the cervix was also attended with temporary relief. But in every case the relief was only partial and temporary. Even after the probable date of the child's death, and the consequent shrinking of the uterine tumor, there was not complete cessation of the symptoms. At about four months of pregnancy labor was artificially induced. The fœtus had probably been dead several days. It was macerated, and presented in

parts a brownish discoloration. The patient vomited but once after delivery, but the nervous symptoms which had existed before did not subside. Death occurred very suddenly. The patient awoke with a start, threw up her hands toward her head, gasped two or three times, and ceased to breathe. There was no autopsy, and the cause of death was never satisfactorily explained. The writer inclined towards the belief that death was due to pulmonary thrombosis, the clot coming from the diseased heart, where it had formed in consequence of the roughened endocardium, and the feeble circulation during the condition of shock which followed delivery.—*Boston Med. and Surg. Jour.*, Feb. 7, 1889.

Jefferson (A.) on a Case of Complete Inversion of the Uterus.—The patient, a primipara of twenty was delivered by a midwife. Shortly after the birth of the child Dr. Jefferson was summoned. On reaching the patient's house he found her in collapse, the radial pulse scarcely perceptible. On examination, there was seen protruding from the vulva a fleshy mass, consisting of the placenta partially adherent to a pyriform tumor, which was quite as hard and as solid to the touch as a dense fibroid. This projected somewhat forward, the upper surface of its neck being pressed up closely against the pubes; *per vaginam* uninterrupted continuity between its surface and the vaginal wall was made out, the finger being inserted about two inches and a half from the labiæ majoræ; no ridge corresponding to the os could be detected; there had been no abnormal amount of hemorrhage. The patient meanwhile was complaining of severe pain in the back. The condition was at once recognized as inversion of the uterus, and the physician proceeded without delay to effect reduction. The placenta was first stripped off; this was adherent over nearly the whole of the frontal zone. Having washed the inversion with carbolized water, the author grasped it with his left hand and pushed steadily upwards, the fingers of the right, applied just beneath the pubes, giving it also a direction backwards, while the body of the organ was squeezed between the two palms. Soon the inversion was found to be retreating into the vulva, through which, and into the vagina, it was followed by the left hand, until reposition was effected, no hemorrhage ensuing. The alarming collapse of the patient yielded to active stimulation, and the patient made a rapid and continuous recovery. The temperature was on only two occasions above normal.

The cause of the inversion was not very clear. The midwife stated that the cord was twice round the child's neck, but not so tightly as she had seen it in some cases. She released the loops, and, the child being born, was surprised to see the placenta and inversion follow it before she had time to tie the cord. From the account of the patient herself, it appeared that directly after the nurse had told her of the birth of her child, she felt "something come down." This caused little or no vaginal pain, but was accompanied by excruciating pain in the lumbar region and left breast, together with a terrible feeling of faintness. It seemed probable that the midwife, in loosening the cord around the child's neck, may have started an introception of the uterine wall, this passing on into inversion in the usual manner. It is noted that there was no vomiting during labor, and also that the patient was in bed for some time before delivery.—*Lancet*, December 29, 1888.

Matheson (A. A.) On a Case of Rupture of the Uterus.—The patient was in her tenth labor. The previous nine had all been easy. The presentation was a brow. Podalic version was performed, and terminated the labor, though there was slight delay with the head. The child was still-born. As the head escaped from the vulva, several large blood-clots immediately followed. Severe hemorrhage ensued directly afterwards, for which friction of the uterus, through the abdominal walls, was employed, ergotin injected subcutaneously, and a hot-water intrauterine injection administered. While removing the afterbirth and using the hot water (which soon controlled the hemorrhage) it was noticed that a tear existed in the uterine wall, to the left side, and somewhat anteriorly. The tear extended from what seemed to be the contraction ring, directly upwards, to not far from the fundus. From the tonic contraction of the uterine muscular fibres the edges of the rent had retracted, leaving a wide gap, into which a large part of the hand easily passed. Though the rupture involved the entire thickness of the muscular wall, the peritoneal covering was felt to be intact.

The patient died after thirteen and a half days. At the post-mortem examination the immediate cause of death was found to have been thrombosis of the pulmonary artery. The author calls attention to the retraction of the edges of the tear, which existed after delivery. Lusk maintaining that the uterine opening in such cases has a tendency to speedily close.—*Edin. Med. Jour.*, February, 1889.

Mackness (O. C.) On the Relative Weights of the Placenta and Child.—While resident at the Edinburgh Maternity Hospital the author was struck with the number of exceptions to the generally accepted rule that the weight of the placenta is in proportion to the bulk of the child. Consequently he started a series of investigations. Two hundred cases were taken without selection from the records of the hospital. Of these cases the average weight of the child was 7 pounds 5.97 ounces, the average weight of the placenta 1 pound 6.8 ounces. Tables were then constructed to show the average weight of placenta for each weight of child; also what weight of placenta any given weight of child should have if the placenta and child are proportional in weight. The tables showed that the variations from the rule that the weight of child and of the placenta are proportional were very striking; and that with any given weight of placenta, children of most varying weights were found. An instance of this was with a placenta weighing 1 pound 5 ounces, fourteen children were born with weights varying from 6 pounds to 8 pounds 15 ounces.—*Edin. Med. Jour.*, February, 1889.

THERAPEUTICS.

Corner on the Antiseptic Power of Salol as a Dressing.—The author uses it for wounds after the part had been rendered aseptic by a 1 in 20 solution of carbolic acid. He does not claim for it greater power than iodoform, and probably other antiseptics, but it had advantage over some. It possesses a pleasant aromatic odor, can be used freely without fear of irritation or poisoning, is absorbent of moisture, which drying forms a hard but friable covering. It will prevent putrefaction; it will not destroy it when once established. It has been used in increasing frequency for several years at the Poplar Hospital, and with excellent results, in compound fractures and dislocations, also as a dressing in amputations, minor and major, and in compound comminuted and depressed fractures of the skull. The first case shown was a compound comminuted depressed fracture of the frontal bone, in which the bone was elevated and some spicules removed. Afterwards the wound was washed with a solution of carbolic acid (1 in 20), the opening filled with salol, and a drainage-tube inserted. The dressing was undisturbed for fourteen days, remained sweet, and healed on the twenty-sixth day. His temperature remained from the first under 100°. A second case treated in January, 1889, was a compound fracture of the olecranon, head of radius, and humerus, opening the elbow-joint, with considerable damage to soft parts, the elbow having been crushed by the passage of a railway engine over it. The olecranon was splintered and drawn up, causing serious tension of skin and necessitating removal of both portions. The antiseptic treatment and dressing were the same as in the previous case, but required changing after four hours and again next day, in consequence of oozing through. The parts were then left untouched for thirty days. The temperature went up the day after the iujury, and remained about 101° for three days, 100° for two days, and then fell to normal. Two other cases were shown: one a crushed compound fractured finger, dressed twenty-one days before, and not exposed since, there having been neither pain nor elevation of temperature; the other was a compound fracture of the first phalanx of finger, only dressed at the time of the accident, and left undisturbed for a month, when it was found perfectly healed. It was pointed out that this was the common experience in such cases, and that even if gangrene followed the parts remained sweet.—*Lancet*, May 4, 1889.

Rochester (D.) on Sulphonal.—It is asserted of the new hypnotic sulphonal, that it has none of the unpleasant after-effects, such as headache, weakness, disturbance of stomach, etc., that usually follow the administration of the other hypnotics. In this connection the following report will be interesting: Miss P., a young woman of about thirty years, a case of Basedow's disease, has been very much disturbed for the last two years by loss of sleep in addition to the usual nervous

symptoms accompanying her disease. As her rest had been greatly disturbed for a week, on Sunday, December 16th, she took thirty grains of sulphonal at 10 P.M., and slept without interruption until 8 o'clock the next morning, when she was awakened by her sister. On attempting to raise her head from the pillow, however, she was taken with such violent pain in the head that she was forced to lay back again immediately. The headache was accompanied by great nausea, which was relieved by vomiting about one hour after she awakened. After the vomiting, the headache gradually passed away, but the patient felt great weakness and trembling of the legs throughout the day. Monday night she took no medicine, and slept with one slight interruption from 11 P.M. until 7:45 A.M., Tuesday, when she awoke feeling better, though still weak. She said she had not slept so soundly in two years as she did Sunday night, but that she would not wish to do so again if the after-effects were to be the same.

However, a few days afterward I persuaded her to try again, this time using twenty-three grains. The result was the same, but in a milder degree. A week later she tried twenty grains, and slept soundly for eight hours that night and the following night without any evil after-effect. In this case it is to be noticed that the sleep-producing effects lasted two nights, the best effect being produced by the smallest dose.—*Med. Press West. N. Y.*, May, 1889.

Kibbe (J. E.) on Antipyrin in Diabetes Insipidus.—On July 14, 1887, I was called to see a married woman of about 50 years, the mother of two children, the eldest 24 and the youngest 15 years old. She was very stout, weighing not less than 225 pounds. Her husband gave me the following account of her case: She had for fifteen years past suffered from an excessive thirst, drinking large quanties of water at frequent intervals. I was shown a vessel holding three gallons that was filled every night before going to bed, and she would invariably drink the whole of this water before the next morning. She drank in proportion during the day. She also drank very freely of milk, it being her principal diet. She passed her urine frequently and in enormous quantities; in fact, she was compelled to urinate every few minutes. Specific gravity, taken only once by myself, while she was in this condition, was 1,008.

Her husband asserts that during the last fifteen years she was never in the least relieved. I was not sent for to treat the diabetes, but to treat a continued fever, which I diagnosed typho-malarial. On finding her temperature to be 105° F., I immediately weighed her out several 30-gr. doses of antipyrin, and ordered one dose to be given every four to six hours. The next morning, after having taken three doses of the antipyrin (in 24 hours), her temperature was 101° F. Her husband informed me that something strange had occurred since the previous evening; at this, she had not called for water during the night, and had only passed her urine once and in normal quantity. I could only suspect that the antipyrin was probably the cause of this sudden change, and concluded to see further.

Fearing to continue large doses of antipyrin, she was given from one to two 10-gr. doses during every 24 hours up to the time of her death, six weeks after the day I first saw her. During these six weeks she never had the slightest return of the diabetic symptoms; she drank naturally, and passed her urine several times a day in normal quantities; in fact, she was doing well until a few days before her death, when her bowels began running off, from which she sank exhausted in 48 hours, as nothing had any control over them.—*New Orleans Med. Jour.*, May, 1889.

Duvall (W. A.) on Scarlatiniform Eruption Following the Administration of Quinine in Confinement.—I was called to attend in confinement a woman of thirty-one years, of general good health. This was her seventh labor, and in the previous six she had experienced no unpleasant complications.

After having completed delivery, as is my custom in such cases, I ordered the following.

℞.—Quiniæ sulphat.,	ʒj.
Acid. sulphuric. dilut.,	gtt. vj.
Syr. limonis,	℥ ij.
Sig. ℥ ss twice daily.	M.

On the third day the right cheek was very much flushed, and, upon investigation, found to be of a burning character. The temperature was found to be 99° F.

Careful investigation revealed nothing further. The next day the flush had extended to both cheeks, and later in the

day a scarlatiniform eruption made its appearance over the face and neck, extending the next day to the inner side of the left; then to right wrists. The itching and burning attending the eruption were intense. The evening of the fifth day discontinued the use of the drug. The following day I ordered an active saline cathartic, with a good result.

Twenty-four hours after I had stopped the quinine, a change for the better was noticeable, even to the nurse. The rash was followed by a swelling very like that which follows a bee sting. Desquamation followed, beginning on the seventh day, and at this time (the twelfth day) has not been completed.

There was no fever at any time of the case. The pulse did not go over 95.

The interesting part of the case is that Mrs. A. was born and raised in a malarial district, and has several times taken quinine *without* bad results.—*Maryland Med. Jour.*, May 4, 1889.

Inglott (G. F.) on Counter-Irritation in Whooping-Cough.—To combat such a distressing disease I have tried the administration of several medicines, namely, bromide of potassium, assafœtida, valerian, morphine, belladonna, etc., and I have very closely watched their effects, but none of them proved of much use. Having observed, however, that during the late cholera epidemic some of the patients admitted into the hospital under my medical charge slept well, had their anxiety removed, and some of them ultimately recovered, after the application of a strong counter-irritation of the pneumogastric nerves in the neck, namely, between the mastoid process and the angle of the lower jaw, I tried the same treatment on whooping patients, and I have no hesitation in stating that the result was very satisfactory. I may quote one single case of the many I have had under treatment.

G. C., a boy aged twelve years, of weak constitution, was suffering from frequent and intense attacks of whooping-cough. At a time the fits were so vehement that blood came out of his eyes and mouth. The case was a severe one, and I thought it would very likely end fatally. I prescribed several medicines, and even subcutaneous injections of morphine, but without any avail. I then tried for the first time the counter-irritation on both sides of the neck, and this means acted like magic. In four or five days the patient recovered, and was able to go to school. Since that time I have been applying the same treatment, either on the right side only, or on both, with the greatest benefit.—*Brit. Med. Jour.*, April 20, 1889.

Hudnut (F. P.) on the Peculiar Action of Potassium Iodide in a Case of Syphilitic Rhinitis.—A widower, aged forty-five, of sober and temperate habits, four years ago contracted syphilis, which ran the usual course. For the past six months he has had more or less discharge from the nose, with considerable pain in the frontal region. The discharge was of a greenish color, and very fetid at times.

Upon examination, I found a condition of syphilitic rhinitis. The septum was swollen and ulcerated, about an inch back from the meatus. Upon the introduction of a probe, I discovered necrosed bone, and passed the probe into the other nostril through a small opening.

Spraying the parts well with cocaine, I removed, with a dressing-forceps, several large pieces of necrosed bone, amounting in the aggregate to the size of a two-cent piece. Upon examining the larynx, found the parts normal. Cleansing the nose thoroughly with permanganate of potash, two grains to the ounce, and coating the membrane with iodoform, I exhibited ten grains of the iodide of potash three times a day, and requested him to call again in three days. At subsequent visits I removed more bone, until healthy tissue was reached, but not until nearly all the septum had been removed, the cartilaginous portion remaining intact.

As there continued to be a large amount of matter discharged from several ulcerated spots, I made an application of nitrate of silver, fused on a probe, to these spots, and sprayed the nose with a ten-grain-to-the-ounce solution of argenti nitras. After using this solution several times, the discharge ceased. As there was considerable hypertrophy of the turbinated bones and some deflection of the septum (cartilaginous portion), I removed the superabundant parts with the cautery and knife, being careful not to weaken the septum too much. I had been increasing the iodide every visit until he was taking ninety grains a day up to this time (about three weeks).

No symptoms of iodism were observed, unless it was a slight increase in the action

of the bowels and an appreciable metallic taste. His general health improved very much, and he expressed himself as feeling very well. After he had been taking the ninety grains of iodide each day for three days, he came to me very much alarmed. I found he had an attack of subacute laryngitis. His voice was very hoarse, and his larynx very much inflamed. After cleansing the parts well with Dobell's solution, I sprayed the larynx with argenti nitras, twenty grains to the ounce. Continuing this treatment for several days and finding no improvement, I decided to stop the iodide and see what effect this would have. On going three days without the iodide, I noticed a decided improvement in his condition. Being aware of the fact that iodide would produce coryza, and in some cases a slight laryngitis, I became very anxious to find out if the iodide was producing the irritation. In order to decide this, I directed him to resume the iodide again in the same doses as before, and to report in three days. In the meantime I gave him no treatment.

Upon the next visit I found him even worse than at the beginning of his trouble. He could not speak above a whisper. I then stopped the iodide entirely, giving no treatment. In three days he was much better, and at the end of the week he was well. I then reduced the dose to ten grains three times a day, and since then he has had no trouble.

In looking up the effects of iodide on the larynx by various authors, only slight reference is made to the action of the iodide on the larynx, and then only when iodism has been produced. Bartholow describes it as a hoarseness and accompanied by coryza, with a rise of temperature. I cannot but feel in this instance that the inflammation of the larynx was entirely due to the iodide.—*Brooklyn Med. Jour.*, May, 1889.

Carter (W.) on Morphine in Uræmia.—My object in writing is to show that the utility of morphine is not confined to chronic cases, as the following, among others which have come under my observation, will show.

On April 11th I was requested by Dr. Glover Moore to see with him a young gentleman, aged twelve, who was suffering from uræmia. Four weeks previously he had had scarlatina. When seen at 12.30 P. M. he was very pale, complained of intense headache, sighed frequently, was confused in mind, and very slow in replying to questions; could not recognize his father standing at the foot of the bed, and stated that he could see nothing clearly. He had had seven severe convulsive attacks, between 5 A.M. and noon. A fit had occurred just before I saw him. Every thing that he took was instantly vomited. The pupils were dilated; the tongue much furred, the skin dry, the bowels confined; temperature and pulse normal. There was no dropsy. From 12 midnight of the 10th to 12 noon of the 11th he had passed about 6 fluid ounces of urine, containing much bright blood; its specific gravity was 1013. Chloroform had been inhaled, and other means employed without benefit. At my suggestion, Dr. Moore gave a hypodermic injection of one-twelfth of a grain of morphine; and, half an hour later, slowly injected into the bowel the enema magnesiæ sulphatis of the *Ph. B.* Three minutes after the morphine was introduced the pupils were normal, and, one hour after, there was considerable moisture of skin. At 7 and 9 o'clock—five and seven hours after the enema—the bowels acted copiously. He slept well all night, and, indeed, from the time of having the morphine, is said by Dr. Moore to have been practically well, every untoward symptom having disappeared.

The dilatation of pupils may to some extent be a guide to the use of morphine under these circumstances. I wish to draw attention, also, to the value of a dilute solution of sulphate of magnesia, in the form of an enema, as a general purgative when the stomach will bear no medicine. The salt is absorbed, and, many hours afterwards, produces a copious fluid motion. If the above were an isolated experience, I should hesitate to put it on record, but it is not so. Under similar circumstances, and the pupils being always dilated, I have had morphine administered some few times, and thus far always with marked benefit; but I have invariably declined to sanction its use where the pupil-contracting element of the uræmic poison prevailed.—*Brit. Med. Jour.*, April 27, 1889.

To Remove the Odor of Uterine Cancer from the Hands.—Dr. Emmet says thymol is efficacious.

Dr. Cheves Bevill, of Winfield, Ark., says:

"Every physician who has had occasion

to treat cancer of the uterus is familiar with the sickening odor of the vaginal discharges accompanying that disease, and how impossible it is to wash the hands with soap and water sufficiently clean to rid them of this ordor after handling one of these cases."

"I have a case under my care now of the cauliflower variety, and the vaginal discharges are sickening in the extreme. I have found that after washing my hands; one application of oil of turpentine to them, followed by another washing with soap and water, removes all odors completely."

The editor of the *Review* says:

"The odorous material, that clings so tenaciously to the hands after handling the abdominal viscera in making post-mortems, may be completely removed or deodorized by the use of oil of sassafras. Doubtless it would answer a like good purpose in cases such as the one mentioned by Dr. Bevill." —*Weekly Med. Rev.*, April 13, 1889.

MISCELLANY.

Williams (W. R.) on Epithelioma of the Lip, Based on the Records of 100 Cases.—Relative Frequency.—Of 15,481 neoplasms consecutively under treatment at Middlesex, University College, St. Bartholomew's, and St. Thomas' Hospitals during the last sixteen to twenty-one years, 352 or 22 % originated in the lip. The relative frequency of the neoplastic process in its other chief seats I have found to be as follows: Uterus 17 %, breast 15 %, skin 8.4 %, connective tissue 6.2 %, tongue and mouth 5.6 %, ovary 5.2 %, external genitals 4.6 %, bones 3.6 %, rectum 3 %, maxillæ 2.6 %, stomach 2.3 %, all others 24.3 %.

Of these 352 *lip* neoplasms 340 started from the *lower* lip, thus:—Epithelioma 329 (M. 326, F. 3), papilloma 7 (M. 4, F. 3), angioma 3 (M.), and cystoma 1 (M.).

Only 12 originated in the *upper* lip, viz.:—Epithelioma 3 (M. 1, F. 2), sarcoma 4 (M. 2, F. 2), angioma 3 (M. 1, F. 2), papilloma 1 (F.), and fibroma 1 (F.).

Analytical summary of 100 *cases of epithelioma of the lower lip in males.*

Seventy-two of these cases were consecutively under treatment at the Middlesex Hospital during the last 13 years, the other 28 cases were under treatment at University College Hospital during the 7 years 1880–86, *q.v.* the Registrar's report.

Age.—The earliest age at which the disease was *first noticed* was 26 years, the latest 75.5 years, and the mean age 52.4 years.

The numbers for each quinquinnial period in 100 cases are as follows:

Age.	Cases.	Age.	Cases.
25 to 30 years	5	55 to 60 years	13
30 to 35 "	3	60 to 65 "	14
35 to 40 "	7	65 to 70 "	9
40 to 45 "	10	70 to 75 "	4
45 to 50 "	14	75 to 80 "	1
50 to 55 "	20		

Total Duration of Life.—In 19 fatal cases the total duration of life, dating from the time when the disease was *first noticed*, averaged 37.7 months.

(*a*) In 7 of these cases the disease ran its course *without any operative interference*; their average duration of life was 16 months, the longest 31, the shortest 7 months.

(*b*) In the other 12 cases the *primary disease had been excised*; their average duration of life was 50.5 months, the longest 96.6, the shortest 10 months.

Duration of Life Subsequent to Excision of the Primary Disease.—In 12 cases the average was 29 months. the longest 96, the shortest a few hours. The subject is further illustrated by the subjoined table:

Duration of life subsequent to excision of primary disease in 12 *cases.*

Age.	Cases.	Age.	Cases.
Under 1 month	1	24 to 30 months	2
6 to 12 months	2	48 to 54 "	1
12 to 18 "	2	60 to 66 "	1
18 to 24 "	2	Over 66 "	1

The Original Seat of the Disease.—This was noted in 59 cases, with the following result:

R. half of lower lip in	21 cases.
L. half of lower lip	21 "
Middle of lower lip	13 "
Angle of mouth (L.)	4 "

The Mode of Origin.—In 30 cases the initial lesion is described as having presented the following characters:

Small sore or ulcer in	16 cases.
Small hard nodule or lump	7 "
Crack	5 "
Hard white speck	1 case.
Wart	1 "

Out of 50 primary cases, more than a single cancerous lesion presented in five, but in every case the disease was unilocal in its origin.

Civil State.—Of 35 cases, married 24, widowers 7, single 4.

OCCUPATION.—This was stated in 36 cases, as follows: Farm laborer in 5 cases, general laborer in 5, sailor in 3, bricklayer in 2, and 1 each of the following: saddler, cowman, blacksmith, stoker, paper factory, piano factory, sewerman, bailiff, gardener, brazier, carpenter, gas-fitter, costermonger, coachman, carman, commercial agent, boatman, waiter, soldier, foreman, and groom.

ÆTIOLOGICAL.—There was history of previous injury or disease of the lip in 35 % of all the cases.

Of 29 cases in which inquiries were made, there was history of previous *injury* in 6, irritation by rough tooth in 1, by plate of artificial teeth in 1, by scratch from meat hook in 1, by holding copper nails in lips in 1, by sting of wasp in 1, and by blow from a stone in 1 case.

Of 26 cases there was history of previous *disease* of the lip (ichthyosis) in 3.

With regard to *syphilis*, inquiries were made in 23 cases, and in two there was distinct evidence of the disease.

Of 26 cases in which inquiries were made as to *smoking*, etc., 16 had been great smokers, and 8 moderate smokers; 5 of the smokers had chewed as well; 2 had never smoked nor chewed.

PREVIOUS HEALTH.—Of 25 cases in which inquiries were made, the previous health is stated to have been good in 24 (with no serious illness since youth in 8), and in 1 case it had been indifferent. Syphilis is *not* included in this statement.

The following previous diseases are noted as having occurred since childhood:

Rheumatic fever in	2 cases.
Pneumonia	2 "
Pleurisy	2 "
Bronchitis	2 "

Lipoma of back of neck, lupus erythematosus, psoriasis, psoriasis of nails, fistula-in-ano, scarlet-fever, yellow-fever, plumbism, abscess, rheumatic gout, and traumatic epilepsy, each in 1 case.

FAMILY HISTORY.—*The fathers;* Of 23 cases in which inquiries were made, in 19 the fathers were *dead*, and in 4 *alive* and well.

The *causes of death* were as follows:

Phthisis in	2 cases.
Bronchitis	2 "
Old age	2 "
Diabetes	1 case
Carbuncle	1 "
Accident	1 "
Inflammation of bowels	1 "
Stricture of urethra	1 case
Stone in bladder	1 "
Total	12 cases.

In 7 cases the *causes of death were unknown.*

Their average *age of death*, in 18 cases, 61.5 years; the oldest 94 (two having attained 80 years), the youngest 38 years.

Of the 4 fathers *still alive* and well, their respective ages were 61, 62, 80, and 82; there was no history of cancer or phthisis in any of their families.

The mothers.—Of 23 cases, the mothers were *dead* in 21, *alive* and well in 2 cases.

The *causes of death* were as follows:

Apoplexy in	2 cases.
Bronchitis	2 "
Jaundice	1 case.
Inflammation of bowels	1 "
Childbed	1 "
Cancer (breast)	1 "
Old age	1 "
Small-pox	1 "
Total	10 cases.

In 11 cases the *causes of death were unknown.*

The average age of death, in 19 cases, was 61 years; the oldest, 83 (the only one who attained 80), the youngest, 30.

Of the two mothers *alive* and well, their respective ages were 60 and 64; there was no history of cancer or phthisis in either of their families.

Consanguinity in the parents.—As to this, inquiries were made in 10 cases, but in no instance were the parents blood relations.

The patients' brothers and sisters.—In 23 families the following *causes of death* are noted among the *adults:*

Phthisis (1 or more deaths) in	5 families.
Cancer	2 "
Apoplexy	1 family.
Insanity	1 "
Scarlet-fever	1 "
Diabetes	1 "
Bright's disease	1 "
Dropsy	1 "
Small-pox	1 "

Of the 2 families in which *cancer* prevailed, in each case the patient's sister had died of the disease, the part affected being the breast in one instance and the uterus in the other.

The *number of members in each family* (in 22 cases) averaged 9.2; the smallest family consisted of two, the largest of 16.

The occurrence of cancer.—Of 87 cases in which this point was specially investigated, there was history of *cancer* in 5

families, or in 5.7 per cent. The *relatives* thus affected and the *seats* of the disease were as follows:

1. Patient's 2 sisters died of cancer, 1 of *breast*, the other of *uterus*.
2. Patient's *mother* died of cancer of *breast*.
3. Patient's *father* died of cancer of *cheek*, and his *mother* died of "internal cancer."
4. Patient's *father* died of cancer of *lip*.

The occurrence of tumor.—Of 84 cases in which inquiries were made there was history of *tumor* in 3, or in 3.5 per cent. Thus:

1. Patient had *lipoma of back of neck*, and his sister had child with *congenital lipoma of back of neck*; this patient's mother died of cancer of breast.
2. Patient's brother had tumor of *cheek*.
3. Patient's sister was operated on for "*internal* tumor."

The occurrence of phthisis.—Of 25 families, one or more had died of phthisis in 6, or in 24 per cent. The relatives thus affected were: Fathers in 2 families, patients' brothers in 5 families. In 1 case there was history of both cancer, tumor, and phthisis in the same family.

The occurrence of insanity—Of 23 families there was history of insanity in two; in both cases the relative affected was the patients' brother.

PRIMARY OR RECURRENT.—73 cases were primary, and 46 recurrent. Several of the primary cases manifested recurrence before leaving hospital, and are here reckoned twice.

The average *interval between the first operation* and the *first obvious recurrence*, in 41 cases, was 20 months, the maximum 110 months.

The following table further illustrates this subject:

Intervals in monthly periods. Numbers for each period in 41 recurrent cases.

Age.	Cases.	Age.	Cases.
Under 1 month.....	2	24 to 30 months.....	5
1 to 2 months.....	3	36 to 42 "	2
2 to 3 "	6	48 to 54 "	2
3 to 4 "	4	60 to 66 "	2
4 to 5 "	3	66 to 72 "	1
5 to 6 "	2	72 to 78 "	1
12 to 18 "	7	Over 110 "	1

In 29 of these 46 cases the initial situation of the recurrent disease was at the *primary seat*, in 4 cases it was *near the primary seat*, but not at it, the scar of the former operation being quite sound.

In the other 13 cases the initial situation of the recurrent disease was in the *adjacent lymphatic glands*, the scar at the seat of the primary disease remaining healthy.

STATE ON ADMISSION.—Of 28 cases, well nourished 16, obese 1, moderately nourished 7, emaciated 6, pale 6, and sallow 1.

The *complexion* was noted in 21 cases; 11 were fair and 9 dark.

The following *lesions, etc., were noted on admission* in 28 cases—Bronchitis, arcus senilis, lupus erythematosus, psoriasis of nails, syphilitic fissure at angle of mouth, posterior synechiæ, each in 1 case.

Condition of the lymphatic glands.—In 72 primary cases there was obvious enlargement of the adjacent lymphatic glands in 36, or in 50 per cent.

In 28 recurrent cases there was obvious glandular enlargement in 25, or in 89 per cent.

TREATMENT AND RESULT.—The disease was *excised* in 64 *primary* cases with but a single death.

In 51 cases the *lymphatic glands were not touched*. All of these recovered. The average duration of their stay in hospital was 18 days.

In the other 13 cases *glands were dissected out* as well. The single fatal case belongs to this group. This patient died of traumatic pneumonia shortly after prolonged artificial respiration for syncope under chloroform. The average period of their convalescence 20 days.

There were 20 operations for *recurrent* disease, without a single death. In 11 of these cases *glands were dissected* out. The average duration of their stay in hospital was 46 days. The average period of convalescence of the other 9 cases, in which *no glands were removed*, was 15 days.

The *causes of death* in 12 other cases were as follows: Asthenia in 8, œdema of glottis in 2, hemorrhage in 1, and cystitis with suppurative nephritis in 1.

THE NECROPSIES.—Of these there were 13. In 9 cases there was marked *emaciation*, in 2 the body was *well nourished*.

The following *non-cancerous* diseases were found:—

Of the Lungs:

Emphysema in..... 7 cases.
Old pleural adhesions (B).....4 "

Hypostatic pneumonia.....1 case.
Congestion.....1 "
Bronchitis.....1 "
Traumatic pneumonia.....1 "

Of the Heart :

Atheroma of the aortic arch in.....3 cases.
Small and atrophied.....2 "
Old thickening of mitral valve.....1 case.
Pale and flabby.....1 "
Normal.....5 cases.

Of the Kidneys :

Chronic nephritis in.....4 cases.
Suppurative interstitial nephritis.....1 case.
Normal.....5 cases.

Of the Liver :

Fatty in.....3 cases.
Congested.....2 "
Cyst (small).....1 case.
Normal.....4 cases.

Of the Spleen :

Small and fibroid, with thickened capsule in.....2 cases.
Normal.....8 "

Other Lesions :

Œdema of glottis.....2 cases.
Small aneurism of aorta 1 inch above cœliac axis in.....1 case.
Acute cystitis.....1 "

LYMPHATIC GLANDS.—In every case but one the adjacent lymphatic glands were infiltrated ; in 8 cases those of *both* sides of neck and the submental ; in 3 cases those of left side of neck ; and in 1 case those of right side.

In 6 cases the *inferior maxilla* was infiltrated and atrophied, and in 4 necrosed as well.

SECONDARY DEPOSITS. — Of these 13 necropsies there were secondary deposits in other parts of the body in 2 cases, or in 15.4 per cent.

The parts thus affected were :—

Lungs (R. 1, L. 1) in.....2 cases.
Kidney (R.).....1 case.

—*Med. Press*, May 1, 1889.

Toogood (S.) on Scurvy in Casual Wards.—During the past year I have noticed six cases, in all of which there were extensive subcutaneous effusions of blood in the lower limbs, the popliteal space being the seat in four cases, and the region immediately above the ankle in the remaining two. Peri-follicular hemorrhages scattered over the legs and thighs were present in all the cases, spongy gums were detected in three, and cardiac weakness in one who fainted while taking the customary bath on admission to the infirmary. All the cases speedily recovered, the treatment adopted being the administration of the tincture of the perchloride of iron and a generous diet including fresh vegetables. They were all males, and belonged to the regular vagrant class who wander from one casual ward to another, and, according to their statements, in none of these wards had they received fresh vegetable food.—*Lancet*, May 4, 1889.

Runnalls (H. B.) on the Successful Removal of a Large Calculus from a Man Seventy-two Years Old.—The following notes are only interesting in so far as they prove that old age has occasionally greater recuperative power than it is usually credited with. During the autumn of 1888 Jonathan Reigard, a German by descent and a farmer by occupation, came to me complaining of all the symptoms produced by vesical calculus. A man of seventy-two began to notice that something was wrong with him about three years ago, and that for the last twelve months life had become intolerable. An examination with a sound made it certain that a large stone was in the bladder. I performed the lateral operation, and after great difficulty extracted a stone weighing seven ounces and measuring three inches long, two inches and a half broad, and an inch and a half thick. The usual after-treatment was adopted, and, although I did not expect it, from the age of the old man, the incision had healed completely at the end of five weeks. Since the operation he has gained in flesh considerably, and whenever he sees me tells me that he has not been so well for the last ten years.—*N. Y. Med. Jour.*, March 16, 1889.

Shield on Complete Rupture of the Left Bronchus at its Junction with the Trachea.—The specimen was taken from the body of a man, aged forty-seven, who had been violently crushed between a van-pole and a wall, the accident proving quickly fatal. In addition to other extensive injuries to the thorax, the third and fourth ribs were broken posteriorly, the fractured ends projecting into the mediastinum. Much blood was effused here, the pericardium was torn, and the aorta ecchymosed, but the heart and main nerves, with the œsophagus, were intact. The lungs were bruised, and not torn. The bronchus was probably lacerated by a fractured rib. Allusion was made to the rarity of the accident, which was hardly alluded to in text-books or in special articles on injuries to the chest.—*Lancet*, March 23, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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LEADING ARTICLE.

Parsons (J. I.) on the Arrest of Growth in Four Cases of Cancer by a Powerful Interrupted Voltaic Current.—According to Gross, 33 per cent. of cancers of the breast are preceded by injury or inflammation. The author is thus led to ask: "Is it not possible that all tumors are in the first instance composed of cells formed in the normal process of repair, but that, having escaped from the control of the nervous system, they take an independent life, and continue to proliferate and develop without check?"

Although devoid of nerves, all tumors have some sort of vascular arrangement, and continue to receive nourishment from the circulation.

In this respect they are on an equal footing with the rest of the body. This appears to form a formidable barrier to any measures taken to stop growth through the internal administration of drugs. Whatever would affect the tumor-cells would also affect the other cells in the body. Considering their origin and the similarity in composition between the cells of tumors and those of the rest of the body, it is unlikely that any drug will be found to exercise a selective influence on the former and leave the latter untouched. Unless this could be done it would be necessary to damage more or less the whole of the body in order to get at the cancer-cells.

There is one point, however, in which the normal cells of the body essentially differ from tumor-cells. Most of the latter show a decided tendency to degenerate, while, in marked contrast to this, the healthy tissues possess wonderful recuperative powers, due probably to the presence of trophic nerves. It therefore seemed to me that if a cure were to be found for cancer, it would be based upon this essential difference between healthy tissue and tumors, and that on account of this difference some agent might be found capable of inflicting an irreparable damage to a tumor, and yet stop short of destroying the normal cells of the body, on account of the higher recuperative powers possessed by the latter. And further, that, although the normal cells of the body are unable to resist the invasion of the cancer-cells, the latter are actually of lower vitality. If such be the case, it may be asked why should the cancer-cells devour the healthy?

The probability is that the difference in composition and structure between the malignant and healthy cells is not sufficient to stimulate the latter to resistance. Consequently, the proliferation of the cancer-cells, resulting from their independent existence, enables them to overcome the healthy cells, since these, for want of sufficient stimulus, remain passive. In a paper read before the British Gynæcological Society in 1888, "On the Action of the Constant Current on Fibroid Tumors of the Uterus," I advanced the following hypothesis: "That while the normal tissues of the body have the power of recuperating any effect produced on them by the transport of elements, the cells of tumors being of lower vitality might be checked in their growth, and perhaps in time destroyed."

Experiments were tried in 1887, which proved that when a current is passed through a tumor no decomposition takes place between the poles. In one experiment, tried on the web of the frog's foot, and watched through the microscope, it was seen that at the positive pole a coagulation took place, with exudation of blood from the capillaries. At the negative pole a collection of hydrogen bubbles could be seen. Between the poles no change could be observed, and the circulation went on as before. While these experiments demonstrated in a conclusive way that the passage of a constant current does not cause any decomposition between the poles, there must of necessity be an exchange of atoms between the molecules. I noticed, in treating cases of fibro-myomata of the uterus by a constant current, that when, as occasionally happens, through an imperfection of the circuit, the current was suddenly interrupted, marked signs of disturbance followed, such as rise of temperature, considerable pain, and *malaise*. Rightly or wrongly, I put this down to some destruction of tissues occurring in the tumor, and, if this conclusion were correct, the means required for the treatment of cancer on the hypothesis advanced has been found.

The most probable explanation of this phenomenon is that the impact of a powerful current, when suddenly flashed through, causes death of those tumor cells which lie in the nearest path between the poles where the lines of force are most concentrated, or else they are sufficiently injured to lead to their gradual atrophy. The latter explanation is more probably the true one, as no rise of temperature or other symptom follows the applications when applied to cancer.

Those cells especially that most require to be destroyed are scattered through the healthy tissues, and each little islet or bird's nest is surrounded by this tissue, furnished with vessels and lymphatics capable of absorbing it so soon as loss of vitality and degeneration occur. I therefore felt no hesitation in trying the destructive effects of a powerful interrupted voltaic current in the first case of cancer that objected to be operated upon in the usual way.

The modus operandi is as follows: The patient is anæsthetized; the current is then passed through the tumor and all the tissues for some inches round it by means of fine, insulated needles, so as not to injure the skin. A battery of 70 cells, with an electromotive force of 105 volts, is used; the intensity of the current to commence with is 10 milliampères, gradually increased to 600 milliampères, and flashed through the growth in every direction from 50 to 100 times according to circumstances. The pulse and respiration were carefully watched. One out of the four cases treated, a woman aged sixty-three, with extensive carcinoma of the left breast, a presystolic *bruit*, and weak, intermittent pulse, was unable to stand more than 250 milliampères, and for this reason: when the current is applied to the left breast electrical stimulation of the heart occurs, and if this organ is healthy an increase in the strength of its contraction appears to take place after its passage; but with the patient who had cardiac disease the improvement only continued up to a certain point, and then the intermittency increased, and great irregularity occurred.

It is only, however, in the immediate neighborhood of the heart and when it is diseased that this takes place. When the current was passed through a secondary growth in the axilla of the same patient, it could be increased to 600 milliampères with perfect safety.

The effects produced by the action of the electricity consist in a cessation of growth, gradual disappearance of pain, some shrinking and hardening of the tumor, and enlarged glands, followed by improved nutrition and better state of the general health. The growth, as a whole, does not disappear, but remains as an inert mass, composed in all probability of fibrous tissue alone.

The cases the author details are four in number.

Case I.—Woman of thirty-eight. Carcinoma of left breast of seven months' growth. Diagnosis confirmed by Bryant; operated on August 23d and 30th, 1888. In following March the growth had become much smaller and harder, and she suffered no pain.

Case II.—Woman of sixty-two. Large carcinoma of left breast of twelve months' standing. Diagnosis confirmed by Bryant; operated on October 4 and 10, 1888. On December 19th there was no pain nor sign of recurrence. On February 2d the axillary growth remaining shrunken, a little renewed activity was noticed about the nipple, and a limited operation was performed, and the patient sent home.

CASE III.—Woman of thirty-six. Excavated and bleeding cancerous ulcer of the cervix uteri. Diagnosis confirmed by Edis, Travers, and Harper; operated on November 18 and December 10, 1888. On March 9, 1889, the uterus had become freely movable and the surrounding tissues free from infiltration. Hemorrhage had ceased, and the pain was insignificant. Emaciation had ceased, and her bladder troubled her none.

CASE IV.—Woman of sixty-one. Recurrent cancer of right breast; operated on January 18, 1889. April 9, 1889, the growth appears to have shrunk, and she has no pain or enlarged glands.

The advantages of this method of treatment are as follows:

1. There is no destruction to the normal tissues of the body, and if recurrence should at any time occur, its progress can be immediately stopped, and the treatment repeated as many times as necessary. Life would by this means be prolonged indefinitely, provided that metastatic deposits had not occurred before the commencement of the treatment. So far, cases able to bear the full strength required have shown no signs of recurrence.

2. Patients are not obliged to lie up, but are able to get about on the day following the application.

3. The current can be passed through almost any part of the body, and thus arrest growths which could not by any possibility be otherwise treated.

4. It will always be open to patients to have the remains of the growth subsequently removed by the knife.—*Br. Med. Jour.*, April 27, 1889.

THERAPEUTICS.

Osborne (J. D.) on Sulphur in Diphtheria.—The doctor asks, What is the use of trying all sorts of unknown and uncertain agents for the destruction of microbes, when we *know* sulphur will destroy them? And if it is said that sulphurous acid is the agent demanded, and that the heat of the body is not great enough to convert the sulphur into this agent, I simply reply, that this condition must be in the sulphur itself, else *why does it do it?* If we want to kill the itch under the skin, we rub in sulphur. If we want to kill lice on birds, or parasites on beasts, we powder them with sulphur. When, after many years' investigation in search of an agent that would destroy the phylloxera that was destroying the vines and prostating the grape industry in all parts of the world, what was it but powdered sulphur that proved the "microbe's relentless foe, and saved the industry," the vine, and the wines?

To be of use in the household the instrument must be cheap, clean, and effective. It must be handy, and made of such material that it can be washed after using with boiling water, and so cheap that no one will hesitate to buy it. This one I describe is made so as to be sold by druggists for twenty-five cents.

It consists of a tube of brass, with a bent spoon soldered on one end. The spoon bent on itself; the whole smooth and without joints, in which poisonous substances might collect; nickel-plated and highly polished. It is to be used by passing it over the tongue, then pressing downward and forward. (I have found the patients, especially children, object much less to this action than they do to the pressure of an ordinary spatula on the middle of the tongue.) The powder then to be blown into the throat and on the tonsils by the mouth-tube of ordinary syringe, by compressing the bulb, or any other insufflator. —*Therapeutic Gaz.*, May 15, 1889.

Cartledge (A. M.) on Bichloride of Mercury in Anæmia.—What is desired to especially call attention to in this paper is the wonderful potency of mercury, more particularly the proto-chloride, as a tonic and curative agent in most forms of anæmia. I am aware the explanation of this will appear to most physicians to be the specific taint which underlies so many of these cases. However, I believe that it exercises its influence for good in cases when syphilis by heredity, remote or otherwise, is no factor in the case. Admittedly, the minute pathology of anæmia is obscure, many times depending on organic lesions of varied character, and situated in different organs. The evidence of anæmia, viz., impoverished red blood-cells or diminution of red blood-cells, does not enlighten us as to the cause of this phenomenon.

The power of small quantities of mercury is known to cause absorption of lymph-deposits anywhere in the system, probably by its stimulation of the glandular system, more probably by relieving the gland-

structures of embarrassment to action, the impediment being micro-organisms which irritate the walls of afferent and efferent ducts, producing engorgements—the mercury acting as a germicide.

Take these properties alone, viz., its power to cause lymph absorption and its influence in relieving glandular engorgement, whether of the great glands, as the liver, kidneys, etc., or of the lymphatic system, and I dare say nearly every pathologist will agree that you have an agent indicated in nine out of every ten cases of anæmia. The deduction is, that while iron has its sphere in feeding the impoverished red cell—and we have abundant proof that it does,—and while the salts of Peruvian bark and arsenic do meet specific causes of anæmia, yet the presence of the deleterious influences soon produce structural changes which are most effectually met by mercury.

While I must express a preference for the proto-iodide in the so-called primary and secondary stages of syphilis, I think, where impoverishment of the red corpuscles has taken place, or in anæmia without syphilis, the bichloride is the preparation to use. The union with the hydrochloric acid seeming to greatly increase the tonic effect, I often give it in doses as small as the $\frac{1}{64}$ of a grain, well diluted, on a full stomach. A most excellent combination is that of the proto-chloride of mercury, chloride of arsenic, and chloride of iron.

Take the anæmia of females, the subject of disease connected with the organs of generation, and I know of no one constitutional remedy the equal of this drug. Nearly all of these cases are the subject of lymph-deposits and ovarian congestion, which is met by an agent which so decidly facilitates healthy gland action. In the chlorosis, which is so often a manifestation of struma, the bichloride of mercury with iron will often effect a cure where iron alone fails. We appreciate the great good mercury does, especially as calomel, in relieving acute glandular engorgement. What I think we need most to be impressed with, is its great virtue in relieving those often obscure and chronic obstructions to gland action which exert so potent an influence for evil in the economy.—*Am. Pract. and News*, May 11, 1889.

Hill (H. G.) on Borax in the Treatment of Epilepsy.—The author narrates the history of an epileptic girl of sixteen. Under strict diet, bathing, frictions, mental and physical training, laxatives, Fowler's solution of arsenic, and nickel-bromide, she still had from two to nine attacks a month. Her stomach became deranged, and she was so depressed that a tonic, of course, had to be substituted, under which the number of attacks became increased to thirteen a month. The hygienic precautions remaining unchanged, she was put on borax, gr. x., in comp. tr. cardamom., ʒ i., in water, one and a half hours after meals.

This borax treatment has now been continued for three full years, and the results are as follows: The attacks have greatly diminished, both in number and severity. There have been periods of complete immunity, extending over several months at a time, a thing before unknown and unhoped for. When attacks did occur there were but one or two during the month, usually to be traced to some slight error in the diet, or too hastily eaten meals. The greatest number of attacks in any one month has been four. There has been uninterrupted physical and mental development, and instead of the flabby, chlorotic, stupid girl, she has become a robust vigorous woman. Menstruation is regular in interval and amount, unattended by neurotic disturbances. Headache has almost entirely disappeared. She no longer shuns society, but mingles with others freely and without distrust of herself. Her judgment can be relied on. Under the instruction of a private tutor she is rapidly making up for lost time. It is now six months since the last attack, and her mother considers her, to all intents and purposes, well.

This remedy possesses advantages in that it does not act as a depressant, and, when given in the manner indicated, does not cause gastric disturbance. Occasionally a slight, scaly eruption is noticed, which can be readily controlled by small doses of Fowler's solution. The dose may be increased to gr. xx., though in the case reported it has never been necessary to exceed the half of this quantity.—*Med. News*, May 11, 1889.

Lawrie (E.). Report of the Hyderabad Chloroform Commission.—The experiments of the Commission were performed publicly, and with every precaution against inaccuracy. The chloroform was given in every possible way, and in no case

did the heart become dangerously affected until after the breathing had stopped. It is a summary of the results of more than 200 complete experiments carried out by the Commission, and it tallies exactly with my own experience. If direct heart failure were one of the risks of chloroform, it must have occurred in some of the administrations which I have superintended; but I have never seen the heart directly affected by chloroform, nor have I ever seen the inhalation carried so far in human beings as to affect it indirectly. *The Lancet* would trust to the heart and circulation for signals of danger in chloroform administration. Our contention is that if the administration is ever pushed far enough to cause the heart to show signs of danger, the limits of safety have already been exceeded, and a fatal result must almost inevitably ensue. So far from disregarding the heart as a factor in chloroform dangers, we say that any affection of the heart, either direct or indirect, is the one danger to avoid. But we say, further, that the respiration invariably gives warnings when a dangerous point is approached, and consequently that it is possible to avert all risk to the heart by devoting the entire attention to the respiration during chloroform administration.—*Lancet*, May 11, 1889.

Jamison (A.) on Bromide of Potassium in Ovarian Acne.—The author concludes that amongst the causes of acne in women, ovarian congestion is one; and that when acne is due to that cause, potassium bromide is at present our most efficient remedy.

Just before and during the continuance of the menses he gives twenty grains of the bromide in infusion of gentian three times a day.—*Practitioner*, May, 1889.

Pope on Strophanthus.—The writer had prescribed strophanthus in sixteen cases. All the cases except two had valvular disease of the heart; the exceptions were one of irregular heart from tobacco and gout, the other a case of renal dropsy. He prescribed the tincture of the strength of one in twenty; the usual dose was five minims. It had produced vomiting in five cases, four of which were females; and he considered that this fact alone showed its inferiority to digitalis, which he had never known produce vomiting except in one case, where it had been prescribed after strophanthus had been discontinued owing to the same cause; even then, on being given in an effervescing mixture, the digitalis was well borne. Having pointed out the manner of its action, he described a typical case of feeble heart, mitral insufficiency, and albuminuria, with anasarca, cyanosis, and dyspnœa, all of which symptoms were much relieved, and the albumen nearly disappeared after its use. He found it, in common with digitalis, to be of most service in cases of mitral regurgitation. In three cases of tricuspid insufficiency it relieved in two; the other died unrelieved. Its effect in the case of functional irregularity of the heart was very good, and it also answered well in renal dropsy. In five cases it did no good. In four it acted well after digitalis had been given with little or no effect. Altogether, it either failed or had to be discontinued owing to vomiting in half the cases referred to. These results, he thought, gave a less favorable view of the drug than it deserved, owing to the fact that many of the cases were of a very severe nature. He thinks that it should be principally used where digitalis failed, or where a specially rapid action was required. —*Br. Med. Jour.*, Feb. 23, 1889.

Saccharin.—An anonymous writer contributes the following to *The Lancet*, May 4, 1889: Saccharin is reputed to be a powerful antiseptic and germicide, and no doubt on good grounds. I therefore wish to put on record that a solution which I had prepared of the strength recommended to replace the simple syrup of the Pharmacopœia (thirty grains of soluble saccharin to one pint of water) developed in about three weeks a vegetation such as occurs in solutions of most substances. Under the microscope micrococci and bacteria could be seen in active movement, a few chains motionless; also some large cells about the size of blood-discs, which I am unable to specify further.

Illingworth (C. R.) on the Pyretic Action of Antipyrine.—In a former letter I pointed out that the antipyretic power of antipyrine and similar drugs was due to their action upon the elements of fibrin —an action which either prevented their union or made the fibrin of so unstable a form that the stasis of blood in inflammatory diseases was either entirely prevented or considerably modified. Confirmatory evidence of this view being correct, I have found in the result of treatment of the commonest disease of leeches after they have drawn blood. In a longer or shorter time

from contraction of ingested material they become hard and corrugated. On treating these with a solution of antipyrine of the strength of fourteen grains to the pint they in three days regained their usual size, suppleness, and activity, after discharging and vomiting shreds of fibrin and a quantity of hæmoglobin; three washings or cleansings were sufficient at intervals of eighteen hours.—*Provinc. Med. Jour.*, May 1, 1889.

Counsell (H.E.) on Can Pneumonia Be Cut Short by Antipyrin?—The patient, aged twenty-one, has had two previous attacks of pneumonia: the first one four years ago; the second last winter—a very severe attack, in which I attended him. On February 25th he went to his work at 5 A.M., feeling perfectly well; at 6 A.M. he commenced to shiver, was then sick, and felt so ill that it was with difficulty he reached home. He then went to bed. At 3 P.M. pain in the left chest and cough came on, and he expectorated some rusty sputa. I saw the patient at 5.30 P.M.; he had then constant short cough, complained of pain in the side, and felt very ill. Temperature 102.6°; respiration 24; pulse 120. On examining his chest, resonance was good in front, with rhonchus under the left nipple. Behind, over the left side, the resonance was high pitched, and from the angle of the scapula downwards there were well-marked fine crepitations. He was ordered fifteen grains of antipyrin at once, and poultices. Next day he told me that after the powder he slept well, The cough and pain became much less troublesome; he still had both, but felt much better. Temperature 98.5°; respiration 18; pulse 70. The condition of the lung was the same as on the previous evening. On February 27th he was much better, and slept well all night. He coughed very little, and had scarcely any pain when he did so. The resonance was the same on both sides of the chest. On taking deep inspiration, crepitations could still be heard over the same area, and loud rhonchus under the angle of the scapula. Temperature normal. On the 28th he was quite well.—*Lancet*, April 13, 1889.

[A question might arise whether this was not a localized pleurisy or localized pleuro-pneumonia intercurrent in a masked case of phthisis.—ED.]

Vineyard (J. H.) on Heroic Treatment of Strychnia Poisoning.—I once was called to see a negro who had, through mistake, swallowed a half drachm of sulphate of strychnia, which he had purloined from his neighbor's mantelpiece, mistaking it for a twenty-five cent bottle of quinine. He learned his mistake by the effect of the medicine.

I chloroformed him until his jaws became relaxed, then poured down his throat six drops of croton oil and one hundred grains of chloral hydrate. I repeated the chloral in smaller doses, and in a little while I had the strychnia in the night-glass and the patient sleeping quietly. I left a vial of chloral to be used when needed, and in just four hours was back home.—*Weekly Med. Rev.*, April 13, 1889.

Pope (F. M.) on Phenol in Enteric Fever.—Gramshaw reports excellent results from the administration every four hours of phenol, gr. i; tr. iodine, gr. iss, in cases of typhoid fever. He says the patient becomes more comfortable after its administration, and that the disease runs a mild course, free from complications.

Dr. Pope has tested this treatment in twenty-two cases, and has convinced himself of its inutility.

The following table speaks for itself:

	No. of cases.	Died.	Percentage of deaths.	Relapses.	Percentage of relapses.
Treated by phenol	22	2	9.1	3	14.1
Not so treated	120	11	9.1	17	13.6

—*Lancet*, April 13, 1889.

Braymer (O. W.) on Nitro-Glycerine as a Heart-Tonic.—In the fourth week of a case of typhoid fever the attending physician noticed some slight irregularity of the heart's action; the patient seemed to be gradually sinking away; stimulants were given hypodermically; shortly afterward the bowels moved, the stool being nothing but clotted blood, and the patient began to sink more rapidly. Large doses of ergot, fluid extract, were given hypodermically. Two other movements of the bowels followed, and the bedpan each time was swimming with bright-red blood. More ergot was given, and cold cloths were applied to the abdomen. At this time the patient seemed to be almost gone; the pulse was not perceptible at the wrist; her body was covered with cold sweat; her face, arms, and lower limbs were icy cold. Four minims of a one-per-cent. solution of nitro-glycerine were given hypodermically, the dose being

repeated in an hour. Next morning her heart seemed stronger; more of the same remedy was given, and by noon of that day marked improvement was noted; the pulse became perceptible at the wrist, and the patient began to get well.—*Med. Age*, April 25, 1889.

PATHOLOGY.

Jones (T.) on Diphtheritic Gastritis or Gastric Diphtheria.—A rickety girl of two years and ten months was seized with diphtheria on December 1st. The sequence of symptoms was as follows: On the third day, dysphagia; sixth day, vomiting; seventh day, dyspnœa and vomiting of blood and dark-red pieces of membrane; eighth day, much increase in dyspnœa, and death.

The tonsils were studded with shreds of a dirty, gray-colored exudation, about one twelfth of an inch in thickness. A similar exudation covered the arches of the palate, the whole of the uvula, and the recess between the base of the tongue and the epiglottis. The membrane readily peeled off, and the subjacent mucous membrane on the posterior surface of the soft palate and on the upper part of the posterior wall of the pharynx. On removing the hard palate and exposing the nasal fossæ, the mucous membrane of the posterior nares was seen lined with a whitish wash-leather sort of membrane, elastic, stretching to a considerable degree, but then breaking off abruptly and with a clean edge. The epiglottis was covered completely on both surfaces with a dirty-gray exudation, which descended and lined the whole interior of the larynx, filling up the ventricles and sacculi, but it ceased abruptly at the lower border of the cricoid cartilage. There was no exudation in the trachea or in the bronchial tubes, but a catarrhal secretion only. The œsophagus was quite normal in every respect. The stomach had a soft, semi-doughy feel, not unlike a portion of intestine that contains fæces of moderate consistence. On opening the stomach, it presented an irregular dark reddish-brown appearance, with a slight olive-green tint. This was found to be the surface of a continuous membrane that lined the whole of the interior of the stomach, but was abruptly cut off at the cardiac and pyloric orifices. The membrane varied in thickness in different places; it averaged about one twelfth of an inch; over the rugæ it was one eighth to one sixth of an inch or more; in some of the sulci between the rugæ it was less than one sixteenth of an inch.

The sites of the rugæ were well seen, and marked by thick elevated longitudinal ridges of false membrane. The membrane was adherent to the mucous surface of the stomach, but it was easy to separate it and peel it away. The under surface of the membrane was marked with depressions, elevations, etc., which corresponded to similar markings on the subjacent mucous membrane, and it was of a dark venous-red color, without the green tinge of the free surface. The membrane was continuous, and might probably have been completely stripped off in one large piece. Except in thickness and color, it differed but little in consistence, elasticity, and fracture from the exudation in the fauces and nares.

On peeling off some of the exudation and exposing the mucous membrane, the latter was seen of a dark-red color and glistening; it was entire, not abraded or ulcerated; it was soft, but without any mucus.

On separating the rugæ, which was readily done by simply stretching the stomach, the spaces between were found of a much lighter color, but studded with innumerable red points. The rugæ themselves were very dark, with a black-currant-jelly-like color, and studded with dark-red punctiform injections from a pin's point to a pin's head in size, round and circumscribed; some had coalesced, as it were, and formed dark-red spots as big as a split pea.

The intestines showed no trace of disease. There was some pulmonary collapse, some emphysema, and some lobular pneumonia. The renal tubules and cells contained an excessive quantity of granular matter. The urine in the bladder was found to be loaded with albumen, and there was much renal epithelium and granular casts in it.

The exudation from the stomach under the microscope presented an irregular, fibrillated, and reticulated appearance, not unlike simple coagulated lymph, and was rendered transparent by acetic acid. Intermingled were numerous red blood-discs and numbers of cells about the size and shape of white blood-corpuscles, granular,

and in many distinct nuclei were seen on addition of acetic acid. Here and there was a columnar epithelial cell. A separate scraping from the free surface of the exudation showed numerous columnar epithelia, free nuclei and granules, and a few starch granules. No sporules or mycelia could be detected, and no sarcinæ.

Sir William Jenner considered that the gastric exudation was a remarkable example of true diphtheritis of the stomach.—*Br. Med. Jour.*, May 20, 1889.

Saneyoshi (Y.) on a Case of Stricture of the Duodenum.—A married woman, aged 27 years, was admitted into Tôkyô Charity Hospital on September 30, 1888.

Family history.—Father died of jaundice at the age of 62 ; mother alive and healthy ; two brothers and three sisters died in infancy. The patient married at the age of 19, and had three children, born when she was 21, 25, and 26 years old respectively. The first and second are living, but the last child died of "hydrocephalus" two months ago at the age of 7 months.

Previous history.—Had been healthy. Her menses began at the age of 16, and were regular. Had a large burn on the right leg, caused by dropping a lamp when she was 18 years old. Four years ago the glands about the angle of the right jaw became enlarged, and some of them suppurated subsequently. No history of syphilis ; does not drink or smoke.

Present illness.—Eight or nine months ago, *i. e.*, about five weeks after her third confinement, she began to feel uneasiness and pain at the epigastrium, loss of appetite, but no vomiting nor hæmatemesis ; several times a day she felt something coming up from the right iliac fossa to the epigastrium with pain for a few minutes. Three months since she complained of numbness in the legs and tips of the fingers and some difficulty on walking.

On admission.—Much emaciated, anæmic, with slightly flushed cheeks. Skin dry and harsh. Temperature 36.8° C. Glands at right side of the neck enlarged, and some scars. On the back of the right leg, stretching above and below the popliteal space, there was a large cicatrix, the result of the burn above referred to.

Tongue pale and smooth, appetite lost, fulness at stomach after taking food, tenderness at the right hypochondrium. No induration or lymph could be found in the abdomen. Bowels open two or three times a day. Liver and spleen apparently normal. Pulse 72. soft. Heart's action feeble, but no other changes.

Respiration 24, weak and shallow, breath offensive. No cough. No marked physical signs. Sensation and motion much diminished in both the lower and upper extremities. The motor power of the legs was lost almost completely, patient being unable to get up or to move.

No alteration in the spinal column.

Mental condition dull.

Urine normal in color ; sp. gr. 1,015 ; slightly acid in reaction ; no albumen.

The case was diagnosticated as simple dyspepsia associated with an attack of kak'ke (which is a common disease here among ill-nourished people). Consequently we prescribed an alkaline stomachic. For a few days she went on without much change, taking small quantities of milk and rice gruel, but on the 5th of October she began to bring up food, after which the vomiting continued till the end. The ejecta consisted of only food or any thing she had taken.

We gave her, without effect, various remedies, such as oxalate of cerium, dilute hydrocyanic acid, effervescing mixture, muriatic acid with pepsin, egg and brandy mixture and nutrient enemata, but she vomited persistently and died of exhaustion on the 13th of November.

The seat of disease remained obscure until the autopsy was made. Throughout the course her temperature was below normal, ranging between 35° and 36.8° C., except one or two occasions, when it went up a little above the normal point. There was no cough nor bleeding. Bowels opened once every four or five days.

Post-mortem examination was made November 14th.

External appearances.—Body emaciated, no œdema.

No fluid in pleural or abdominal cavities, but pericardial fluid slightly increased, with no flakes of lymph.

Pleuræ free from adhesions.

Lungs.—The left weighed only 6½ ounces, the right 9 ounces. In the lower part of the latter there was some congestion, otherwise both lungs healthy.

Heart.—Flabby and pale, weight four ounces. No lesions of the valves.

Liver.—Darkish in color, otherwise healthy. Weight 31 ounces.

Spleen.—Weight 3½ ounces, rather tough.

Kidneys.—Each weighed 3½ ounces, capsules not adherent, apparently healthy.

Stomach.—No marked changes, mucous membrane appeared to be thickened.

Duodenum.—In its second part we found a constriction through which we could not pass a finger, but succeeded in passing a director without difficulty.

On cutting it open we found ulceration of the mucous surface situated just above the annular stricture, above which the gut was much dilated.

A scar was found at the upper part of the jejunum. Other parts of the intestines were healthy but much attenuated.

Brain.—Normal.

Lymphatic glands at the right side of the neck swollen and cheesy on section.

What was the cause of the duodenal stricture? Could it be the burn inflicted some nine years ago, or some other state such as tubercle? We thought there was some possibility of its being the latter, because the patient had caseously degenerated glands. There were no clinical symptoms pointing to tuberculosis; on the other hand, it must have been very unusual if it were the result of a burn.—*Sei-I-Kwai Med. Jour.*, April, 1889.

Monroe (G. J.) on the Unity or Duality of Syphilis.—A young man came to me some time ago, about three days after intercourse, with a well-developed case of chancroid. The sore was eaten into the parts, with excavated edges, but there was no hardness or induration. I inoculated his leg and a well marked chancroid resulted. In a short time a bubo developed and went on to suppuration. Every indication pointed to chancroid, and chancroid only, and so I told my patient. The sore healed kindly under the use of dry calomel. What was my surprise to find, in about seven weeks, a case of secondary syphilis. The syphilides were present, sore-throat, etc. The young man positive asserted, and I believe truthfully, that he never had but this one intercourse in his life. The mercurial treatment soon controlled the symptoms.

At his special request I visited the girl with whom he had had the intercourse. I examined her thoroughly. She evidently, at the time of intercourse, had a chancroid, but at this time it was entirely healed. There was not the slightest indication of any secondary symptoms, which proved to my mind that she had no syphilis. She had taken no medicine for syphilis, so the symptoms could not have been masked. She stated that she had had no intercourse with any one for several days prior to this time. This young man had the connection with her on a Sunday night. On the Thursday night before she had intercourse with a drummer, a stranger to her. Is it possible that this drummer could have deposited syphilitic virus in her vagina at that time, which remained inert until the Sunday night when the young man had intercourse with her? If so, why was the girl not affected, as she no doubt had a chancroidal sore at the time? I have watched her closely, and no syphilitic symptoms have shown themselves, and it is now over three months since the occurrence. I called it a missed case. Still, if my patient had chancre, why was it not indurated? Why was it inoculable? Why did the initial sore develop so soon? If it was simply chancroid, why the secondary symptoms? Why was it controlled by specific treatment?

I do not fully understand the case. This I do believe, however: he had chancroid, and he also had constitutional syphilis.—*Med. Record*, May 18, 1889.

Wilde (L.) on Dermoid Cyst of the Lumbo-Sacral Cord Simulating Spina Bifida.—A dermoid cyst was removed from the lumbo-sacral region of a man, aged twenty-three, by Mr. Holthouse. The cyst, which was the size of a turkey's egg, was lined with piliferous skin. Four days before removal it had been opened, and pultaceous matter and loose hair removed from the interior. Observations made upon the cyst-wall showed that it possessed tactile sensibility, and perspired like the surrounding skin. The tumor was exhibited to the Society on account of its great rarity and the difficulty of diagnosing such a cyst from a spina bifida tumor. Mr. Bland Sutton said that this case was chiefly interesting on account of the difficulty of forming a differential diagnosis between this and cases of spina bifida. The case was also interesting as proving that dermoid cysts contained nerve-end organs.—*Br. Med. Jour.*, Feb. 23, 1889.

Baker on Incised Wound of the Stomach.—The doctor had been summoned to attend a boy who had been cut badly while in church. He had expected a wound of the arm or shoulder, and had

gone only with a pocket-case. The place was two and a half miles from town, but he had ridden rapidly, and had found the boy in front of the church on the ground, the congregation about him. The cut had been made with a pocket-knife, and was three inches long, extending to the ensiform cartilage under the border of the ribs and into the stomach, from which food had escaped. On examination the finger entered the stomach.

The speaker had a young physician with him, and with his assistance had withdrawn the stomach through the external wound sufficiently to expose the seat of the injury. This was a difficult manœuvre, as vomiting was excited. With it also there was expelled from the wound a large quantity of black fluid blood. He had finally united the rent in the stomach, and had closed the external wound. They had had no chloroform, and performed this operation simply with the help of a hypodermic dose of morphine. Two spurting arteries, one of which required ligating, were encountered, but in spite of the crudeness of the operation and the fact that probably blood and fragments of food were left in the peritoneal cavity, the boy had recovered, and his temperature had at no time been above 102°.—*Post-Graduate*, April, 1889.

Lucas (A.) on Foreign Body in Scalp, Causing Necrosis of Skull.—A boy, aged seven years, was brought to the hospital with the history of having, about one month previously, fallen down at school whilst carrying some slate-pencils, one of which, as he fell, ran into his scalp and broke off. It was not removed, and, besides poulticing it, nothing was done. On examination there was found to be a swelling near the anterior fontanelle, at the lower part of which was a small discharging sinus. A probe passed in discovered a foreign body, which, on removal with small forceps, was found to be a thin plate of bone three quarters of an inch long and half an inch broad. On further examination a piece of slate-pencil nearly one inch in length was found and removed. After this the wound still healed, and the boy completely recovered, with the exception of having a depression of the size of a penny in his skull.

In this case the piece of pencil must have become imbedded under the pericranium, and, setting up acute inflammation, cut off the blood-supply to the bone, so causing necrosis of the outer table of the skull. It would not, I imagine, have been able to penetrate the outer table and become fixed in the diplöe.—*Br. Med. Jour.*, May 4, 1889.

Randall on Cerebral Abscess Secondary to Ear Disease.—A girl, four years of age, was admitted to the Children's Hospital with suppuration of the mastoids and strumous suppuration of the left elbow-joint and thumb. Facial palsy was complete on the left side, and there was caries of both temporal bones. Sequestræ were at various times removed, and the ear condition improved. The thumb was amputated, and the elbow-joint excised, and, though the operation was well borne, the child gradually sank, and died without, however, any cerebral symptoms. An examination of the eye-ground had been impossible. At the autopsy the meninges appeared normal, except over the left tegmen tympani, where the dura was destroyed over an area ten mm. in diameter, and an irregular gap was found in the bone beneath. An organized clot in the outer part of the left lateral sinus was loosely attached to the sinus wall, which seemed normal, and no involvement of the underlying bone was found. A large abscess in the left spheno-temporal lobe, above the opening, in the roof of the tympanum, had evidently burst, and evacuating itself through the ear, had given rise to the gush of pus preceding death. There was little or no exudation on the basilar meninges. The lungs were full of cheesy nodules.—*University Med. Mag.*, March, 1889.

[The absence of cerebral symptoms in this case seems extraordinary.—ED.]

Whitney (R. L.) on Ephemeral Aphasia.—On April 24th. a woman, æt. 69, while engaged in conversation, suddenly stopped in the midst of a sentence, apparently having forgotten a word. The stoppage was so sudden as to arrest my attention, and caused me to remain in the room, which I was about to quit. The woman continued to knit for about a minute, when the head and eyes were sharply turned to the left with an expression of terror. Aphasia was complete. The tongue could be protruded straight and in all directions, but could not be brought to a point; there was no other sign of muscular paresis. Towards evening she tried to write—agraphia was complete, and though the attempt was fluently made the

result was wholly unintelligible. There was also complete word blindness, but the powers of hearing and understanding were intact. This state of things continued throughout the second day, with the addition of a very slight fall of the mouth to the right, which had completely disappeared by mid-day. On the morning of the third day could with difficulty express herself with a few words thickly pronounced, and could write her children's names. Much improved towards evening; slept well during night. Fourth day, can write as well as ever, and can articulate all words except those containing "s" or "th"; feels well. Fifth day, can speak fluently, articulating all sounds except "s." Sixth day, "s" sounds tolerably good. There have not throughout been any signs of paralysis or paresis beyond those mentioned.—*Medical Press*, May 8, 1889.

Stair (J. B.) on a Fatal Case of Diphtheritic Paralysis.—On February 2, 1889, I was called to attend Lida V——, aged nine, whom I found suffering from diphtheria of twenty-four hours' duration. The disease ran a moderately severe course of five days, at which time the deposit had wholly disappeared, the mucous membrane looked healthy, and restoration to health seemed certain and speedy. Considerable feebleness followed, however, and strength was regained slowly. About four weeks subsequently the little girl laughingly called her mother's attention to the fact that in drinking water some of the liquid refused to "go the right way," but came back through the nose; this difficulty in swallowing was a persistent symptom and became quite troublesome later. Paralysis of the vocal muscles also appeared early, and speech was painfully incoherent. Soon following this the disease attacked the lower limbs, and for a week she could not walk without assistance; but this disappeared to a great extent later. The arms were at no time affected. With some variation as to location there was little change for three weeks. Three or four days before death considerable somnolence developed. But the fatal result was directly due to paralysis of the heart and respiratory muscles, symptoms of which were speedily followed by death.

I have attended twelve cases of diphtheria within the three months past, some of which were much more severe than this one, but in none other were paralytic symptoms manifested, save in one, which had a temporary squint.—*Med. Record*, May 18, 1889.

Dickinson (W. H.) on a Kidney from a Patient in whom Albuminuria was Hereditary.—The specimen belonged to a member of a family in which albuminuria had been hereditary certainly for four generations, and possibly for more. He had referred to this remarkable piece of family history in his book on albuminuria, but was now able to give it more fully, and with the additional information derived from a *post-mortem* examination. He related the particulars of this family, which were as follows: The first generation consisted of a brother and four sisters. The brother died suddenly, after a long wasting, "of kidney disease in some shape," at the age of thirty-four. Of the four sisters, two died at the respective ages of forty-nine and forty-eight, each having had albuminuria for many years. The brother left six children, two sons and four daughters. Of the six, four became the subjects of albuminuria, the second son died with it at the age of twenty-six, having had it since the age of twelve. The eldest daughter died of it at the age of thirty-nine, having had it since sixteen; the second daughter still alive has it; the third daughter died of albuminuria complicated with diabetes. All the sisters had left children; two of the four transmitted albuminuria. The eldest sister left six, presently to be mentioned. The third left five, one of whom had albuminuria. These constituted the third generation. Of the six children of the eldest sister, five became subject to it, and only the second son escaped; the third son died with it, and was the subject of further particulars. The disorder presented itself in the fourth generation in the only child of the eldest sister, which was born with albuminuria. To these facts were added others, which showed the existence of the disease in a collateral line, as was shown in a table placed before the Society. It was stated that the portraits of this family, which have been preserved since the time of Edward IV., showed a peculiar pallor, whether from time or disease, which resembled that which had generally characterized the living and late members. Particulars relating to the character of the albuminuria in many of the persons referred to were briefly related, showing the general presence of casts and

other evidences of renal disease. The kidneys of the only fatal instance in which they were fully examined were described in detail. They presented the characters of the granular contracted kidney, with general fibrous hypertrophy, universal prevalence of a finely nucleated interstitial tissue, atrophy of many of the Malpighian bodies, with atrophy of many tubes and dilatation of others, the latter being conspicuously plugged with large casts. An exceptional appearance was the existence sometimes within the tubes, sometimes in less evident relation to them, of numbers of minute calcareous concretions, which were possibly formed within the tubes, as a result of their obstruction. It was discussed whether any calculous proclivity in the family was antecedent to the renal state, and this possibility was negatived by a review of the general clinical antecedents. The conclusion remained that some especial hereditary influence was directed upon the kidneys primarily. Dr. Dickinson had formerly referred to this family history as one of the hereditary granular kidney. What before was only a surmise was now a pathological fact, and as such, possibly worthy of the notice of the Society.—*Br. Med. Jour.*, May 11, 1889.

Manby (A. R.) on the Pathology of the Central Nervous System in Exophthalmic Goître.—I have been seeing lately a great many cases of diabetes, and the following facts are at least of interest in this connection, although they cannot prove positively the locality of the cerebral centres either of exophthalmic goître or of diabetes. But when considered with Dr. Hale White's recent observation, and also with the well known earlier experiments of Bernard, Schiff, and others, they certainly suggest a more intimate connection between the two diseases than their usual classification in nosology.

Case 1.—A., a retired naval officer, died of diabetes, aged 70, leaving, with other issue, a son, A. A., aged 45, the victim of diabetes, and a daughter, A. F., aged 40, the subject of goître, exophthalmos, and irregular action of the heart.

Case 2.—B. died of diabetes, said to have been caused by a fall on his head, aged 19. Some twenty years later, his brother, B. M., aged 50, lost two children with acute diabetes; and a sister, B. F., died, having suffered for several years with exophthalmos, goître, palpitations, and semi-maniacal mental disturbance, which appeared to alternate in a marked manner with the enlargement of the thyroid gland and the prominence of the eyeballs.

Case 3.—C. A. and C. B., two sisters, died of acute diabetes, aged respectively 9 and 10 years, and fifteen years later a younger sister, aged 23, developed enlargement of the thyroid with exophthalmos and heart symptoms.—*Br. Med. Jour.*, May 11, 1889.

Canfield on the Relation of Dusty Occupations to Pulmonary Phthisis.—The dust inhaled by miners in badly ventilated mines gradually overcomes the action of the ciliated epithelium, and penetrates to the alveoli of the lung, whence it finds its way into the subepithelial layer, where, unless rendered harmless or devoured by the greedy phagocytes, it sets up a fibroid condition of the lung. Most writers agree that the fibroid condition is a barrier to the growth and multiplication of the bacillus.

The author relates the case of a miner who had a fibrosis of the lungs, and in whose sputa bacilli were always found at every examination, and yet this man improved and is now well.

The patient had no previous history of, or predisposition to, tuberculosis, and he contracted a disease with which tuberculosis is supposed to be very rarely found.

Although he had tubercle bacilli in abundance in his sputa, he is now entirely well.—*Med. Record*, May 18, 1889.

Taylor (H. H.) on a Case in which the Left Auricle Pressed on the Left Bronchus.—The patient, a lad, had suffered from dyspnœa and palpitation for three years. The area of cardiac dulness was much increased. There was a presystolic thrill and murmur; the liver was enlarged and pulsatile. The pericardium occupied the greater part of the left side. The left pleura contained about one pint and a half of amber-colored fluid. The heart was considerably enlarged; the mitral valve was slit-like, and admitted one finger; the margins were thickened and rigid; the left auricle was enormously enlarged, the wall being nearly a quarter of an inch thick, and the cavity contained eleven ounces of dark clot. The left bronchus passed behind the left auricle in close contact with it, and was flattened from before backwards in its whole length.—*Lancet*, May 11, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON M.D.

With the active collaboration of

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LEADING ARTICLES.

Nephrolithotomy.—In a paper published in the *Medical and Surgical Reporter* for Sept. 29, 1888, entitled "Results of Nephrolithotomy and Nephrectomy," Dr. Charles Baum says: "The first premeditated incision through the sound tissues into a kidney, for the removal of a contained calculus, was successfully performed by Henry Morris, of London, England, in 1880. The operation was named nephrolithotomy, and under this term he intended to designate the cutting a stone out of a kidney which, so far as can be ascertained by clinical examination, is not dilated or otherwise altered in form, and which, but for the presence of the stone, is presumably healthy. At the present time most surgeons have extended the original definition of nephrolithotomy so as to embrace cases in which there may even be some slight external fulness in the loins, yet not the pointing of an abscess, nor in which the renal tissues have not ruptured." He then gives a table of 50 cases operated upon, of which 28 were males and 22 females. Of the 50 cases 42 recovered and 8 died, or 16 per cent. Of the 8 fatal cases, 4 could with great propriety be eliminated in computing the death-rate, reducing the mortality to 8 per cent.

One of the cases reported in which recovery resulted had had her ovaries separately removed for the relief of the pain, which was ultimately traced to the condition of the kidneys.

Of the 50 cases, 41 were operated upon according to the method adopted by Morris, the incision being made parallel to and about ¾ inch below the last rib.

At the meeting of the Genito-Urinary Association, in Washington (Sept. 20, 1888), Dr. W. Gill Wylie advocated the anterior operation because of the greater freedom for action it presented. Dr. Weir criticised the abdominal incision as an unnecessary opening of the abdominal cavity for a purpose which could be obtained just as well in most cases by the lumbar incision, but emphasized the importance of making the incision very free in whatever location it was made (*Med. Record*, Sept. 22, 1888). In the *Lancet* (Jan. 7, 1888), Mr. Pick says: "I prefer the transverse incision to the oblique or vertical one—that is to say, an incision from the anterior extremity of the last rib transversely backwards to the border of the erector spinæ, not running parallel to the rib, but in such a direction that its posterior extremity was about an inch, or rather less, below this bone. This incision seems to me to give more room for exploring the kidney than the slight oblique one, which is often recommended, parallel to and three quarters of an inch below the rib."

Kendal Franks, F.R.C.S.I., in the *British Med. Jour.* (March 31, 1888), reports a case in which, after making the usual examination of the kidney by palpation and exploratory punctures in every direction, and failing to detect the stone, he determined to make the exploration complete

by incising into the kidney substance. The employment of these measures was followed by the discovery of a small calculus about the size of a pea lying in an abscess cavity close to the pelvis of the kidney. The history of this case is still further interesting from the fact that the hemorrhage from the kidney being quite free, a small plug of carbolized gauze was introduced. For two days after the operation the patient was troubled with incessant vomiting which nothing seemed to check. It suddenly occurred to the operator that the vomiting might be reflex from the kidney, due to the irritation of the plug, as nausea is so persistent a symptom of renal colic. On removing the plug the vomiting entirely ceased.

Dr. Stevenson and Dr. Butler Smythe (*Med. Press*, March 27, 1889), reports a case of hydronephrosis caused by renal calculi, in which death resulted seven days after the operation, from hemorrhage due to ulceration into a branch of the renal artery.

In the *Practitioner* of November 8th, Rickman Godlee tells of a case in which the sinus resulting from a nephrolithotomy was dilated with a bougie, for the extraction of some grit which lay at its bottom. On the removal of the bougie, it was found to be smeared with fæces, showing that it had entered the colon, which had prolapsed into the wound. The puncture caused no trouble beyond the escape of gas and a small amount of fæces for a few days.

GERTRUDE B. KELLY, M.D.

On Suspension in the Treatment of Locomotor Ataxia.—While not questioning the propriety and efficacy of suspension in the radical treatment of treason, murder, rape, and arson, we must adhere to the statement made in THE ANALECTIC of February 28, 1889, p. 98, when, after calling attention to the startling results of Charcot's treatment of locomotor ataxia by this method, we said: "This is all too good to be true, and further experiment will undoubtedly prove the fallacy of these hasty deductions." Curing sclerosis of the posterior columns of the cord by suspending a patient by the head and axillæ or elbows is about as rational as gunning for the bacillus tuberculosis via the rectum with sulphuretted hydrogen, and the former treatment will undoubtedly follow the latter to an early grave.

The more recent clinical reports throw much cold water on the too sanguine early claims.

In the experience of Dr. Charles L. Dana[1] the treatment has yielded no very promising results.

The treatment has been tried in six cases of locomotor ataxia, and in one of Friedrich's disease, also in paralysis agitans, transverse myelitis, hemiplegia, and sexual neurasthenia, sixteen cases in all. The suspensions were made with a Sayre apparatus; they were given three or four times weekly, beginning with half a minute, and extending to over three minutes.

The results so far obtained are these: In one ataxic, sixteen suspensions, there was improvement in subjective feelings in the lower limbs and a steadier gait, no other change. In a second ataxic, ten suspensions, slight improvement. In a third ataxic, who was suffering intensely from lightning pains, no improvement after seven suspensions. In the other ataxics a few suspensions have been made only. The patients say that they feel better and freer in the legs for a day.

In the cases of paralysis agitans one patient felt much better after two suspensions; and it gave him so much relief that he used to hang himself from the top of the door at his home several times daily. He has had eight suspensions.

The second patient, after nine suspensions, thinks his stiffness somewhat improved. The most enthusiastic seeker for suspension is a patient with transverse dorsal myelitis. After thirteen suspensions he really seems much benefited in freedom and strength of movement. The same remark applies to a patient with cerebral hemiplegia who has had nine suspensions. The case of Friedrich's disease claims to feel better than he has for a long time.

The writer has noticed exaggerated reflexes (in those who have n't ataxia) during suspension. The circulation in the arms is impeded, and the pulse often can not be felt at the wrist.

The author thinks it a method of treatment inferior in importance to others in our possession and a measure of minor and occasional value.

From some experiments made he thinks that better results, as far as some symptoms go, may be had by partial suspension by the heels.

[1] *Med. Record*, April 13, 1889.

Dr. Robert Saundby's experience[1] is not so flattering, in spite of the fact that he employed at the same time counter-irritation and potassium iodide. He has treated three cases.

CASE 1.—A man of 52, was admitted January 24th with lightning and girdle pains, ataxy, loss of pupil reflexes and knee-jerks and ability to stand with his eyes shut; entire loss of vesical reflex and of power of voluntary micturition. He was suspended first on January 28th, and since then has been suspended twenty-one times, generally for two minutes, sometimes for fifteen or thirty seconds longer. He complains of no disagreeable effects, except singing in his ears during the time he is suspended. He is a small, light man. In addition to this treatment, he has been blistered down the spine, and has taken 30 grains of iodide of potassium three times a day. His present condition (February 24th) is: no girdle pain, very little lightning pain, walks better, passes an increasing quantity of water voluntarily; knee-jerks, pupil reflexes, and inability to stand with eyes shut are as they were.

CASE 2.—A man of 40, admitted January 28th with lightning pain, gastric crises, ataxy, inability to stand with eyes shut, no knee-jerks or pupil reflexes. He has been suspended seventeen times; as he is very nervous, the duration has averaged under two minutes, though lately this period has been regularly attained. He formerly complained of "fulness of the head," lasting for some hours after the operation, but he does not do so now. His pains are better; he has no gastric crises since admission, but he is otherwise not improved. He has been taking 30-grain doses of iodide of potassium three times a day.

CASE 3.—A man of 34, admitted January 24th, with girdle and lightning pains, ataxy, and inability to stand with his eyes shut; knee-jerks exaggerated, pupil reflexes present. There is a distinct history of syphilis. He has been suspended fifteen times since February 3d. In addition, he has taken 30 grains of iodide of potassium three times a day, and has been blistered down the spine. At the present time his pains are better, but there is no other improvement.

The *Lancet* of March 16, 1889, editorially says:

"In estimating the good or evil effects of treatment, it is most necessary to have regard to the natural history of the disease. Many individuals are under the impression that once the diagnosis of locomotor ataxy has been pronounced by a competent authority there must be an end to all hope. This view is entirely erroneous. Physicians of experience can quote cases of stationary tabes dorsalis by the score, and stationary at any period of the disease, from its first dawn to its last flicker. Cases are also known in which positive recession of the disease, and even considerable improvement, if not practical recovery, either with or without treatment. On the other hand, cases may steadily descend from bad to worse; but a slow and steady progression is by no means the rule, long intervals of slowly progressive impairment may be broken by short sharp shocks of sudden deterioration; indeed, the variety of the clinical history of these cases is as complicated as the imagination could picture."

As to the *modus operandi* of the treatment the most improbable explanation is that of Althaus,[2] who considers it a "breaking down of adhesions from chronic meningitis," or that by stretching the spinal cord "the overgrown and unduly hardened neuroglia (of the posterior columns) may be loosened and broken down."

The majority of writers on the subject hint that the spinal cord is stretched by the procedure, and that this explains the results of treatment.

Not one atom of proof has been adduced that 100 to 150 lbs. of extension applied to the spine can stretch the spinal cord a millimetre. Any elongation of the spinal column would be first felt by the spinal nerves, and it has long since been proven that nerve-stretching has at best only a temporary palliative effect upon the disease.

It should always be remembered, as the *Lancet* says, that the disease is about as atypical as any we know. There are benign cases which attain a certain stage and stop; there are malignant cases which go from bad to worse, and end fatally from crises, exhaustion, vesical troubles, or gangrene; there are others which, as a result of treatment, or independent of it, have long stationary periods or show temporarily sudden improvement. The treatment of

[1] *Br. Med. Jour.*, March 2, 1889.

[2] *Lancet*, April 13, 1889.

such an erratic disease is of course beset with uncertainties, and any deduction should be the result of prolonged observation on many cases.

So far we see no reason to discard our old friends, the actual cautery and the iodide of potash, which, in times past, have rendered such excellent service in the treatment of this disease.

OCCASIONAL REPORT ON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Cox (James). Notes on a Case of Ear Disease, Followed by Intra-Cranial Mischief.—A woman, domestic, 26, ill 10 months admitted to hospital. Caught cold in her ear at a railway station; five days later noted a discharge unattended by pain. This continued for 8 weeks when giddiness came on causing her to reel, generally to the right side. For some time before admission has vomited without nausea or any apparent cause. Examination showed a purulent discharge with a large polypus. No pain or tenderness on pressure over the mastoid. From the thought that the vomiting might be cerebral the mastoid was opened and found filled with cheesy unhealthy granulation tissue and carious bone. Severe venous hemorrhage occurred, giving the idea of wound to the sinus. After stopping this a loose fragment of bone was removed allowing an ounce of pus to escape, the dura mater being felt in the bottom of the wound. Irrigation and antisepsis were instituted and the condition improved for six days, when suddenly after a screaming fit death took place. Post-mortem showed a large abscess in the right hemisphere of the cerebellum. The rupture of this with hemorrhage into the sac was the cause of death. There was also found the remains of an abscess in the middle fossa. The lateral sinus was healthy. The vomiting was the chief symptom causing suspicion of cerebral trouble.—*Australian Med. Jour.*, March 15, 1889.

Harle (W. J. V.). Dermoid Cyst of the Orbit Treated by Inunction of Iodide of Lead Ointment.—The tumor sprung from the inner margin of the right orbit and extended over the forehead; soft, somewhat movable, and not adherent to the skin, and painless. The patient, after using each night the ointment of iodide of lead, returned showing complete disappearance of the tumor without any trace of it discernible.—*Lancet*, Feb. 22, 1889.

Buckner (J. H.). Recurrent Fatty Cyst of the Orbit Growing from the External Sheath of the Nerve.—In May, 1878, a child 10 years old was first seen with a tumor projecting from the external canthus of the left eye. It grew very slowly at first, but for a few months previously more rapidly. The growth on removal was found to be lardaceous. In Jan. of 1888 the young woman reappeared, saying that for the past 12 months she had noticed a growth in the place of the first operation. A second operation was performed, the cream-like contents of the cyst escaping and so making its eradication more difficult. The operation was followed by severe cellulitis which slowly subsided. An analysis of 73 cases collected and reported by Berlin shows the important fact that orbital tumors of this class occur more frequently under 20 years of age, and that a large proportion of them are congenital.—*Jour. Am. Med. Ass'n*, Feb. 26, 1889.

Wiesner (D. H.). A Case of Melanotic Sarcoma of the Orbit in a Girl Six Years Old.—In Sept., 1887, case appeared with history of two slight injuries 7 and 2 weeks before. Several other children in the family all well. No hereditary taint found. The most prominent symptom is a right exoptholmos. There is no pain, and though pale and anæmic the child appears well. At the inner canthus is a conical semi-fluctuating swelling. One week later a hypodermic needle drew only dark blood but no pus. In November the tumor had greatly increased in size, nodular, painless, with enlarged tortuous veins. Pain appeared in a few days and the swelling and globe were thoroughly removed, leaving only the periosteum of the orbit. Healing took place rapidly and was complete. In 6 weeks a small nodule was detected at the same position where the first started. In February the growth was again removed but hindered its progress only 3 or 4 weeks. By May, 1888, it had assumed great proportions, encroaching on the left side of the face. Another nodule appearing at the angle of the jaw and one in the

right axilla. Two or three points of ulceration starting, pain was complained of in these. The child now could not sleep, sank slowly, and died from asthenia in July. Both operations were attended by very profuse hemorrhages. The period of growth was 10 months.—*International Jour. of Surg.*, April, 1889.

Dowling (F.). The External Ear Appendage: Its Physiological Uses.—After reviewing weighty opinions of noted investigators as to the part played by the auricle in hearing, the conclusion reached is that it is rather for beauty and as a rudimentary organ except under exceptional circumstances.—*Cincin. Lancet-Clin.*, May 18, 1889.

SURGERY.

Keyes (E. L.) on the Question of the Radical Cure of Deep Urethral Stricture.—The conclusions of the author are: 1. There are three forms of organic deep urethral stricture: The superficial linear fibrous, with inflammatory and spasmodic complications (which I call the *soft* stricture); the purely cicatricial fibrous stricture; and the inodular stricture, in which there is development of new inodular tissue over and above the true fibrous cicatricial element.

2. Soft strictures are occasionally (but by no means always, capable of radical cure by dilatation—and the addition of mild electrolysis does not prevent this cure by dilatation.

3. Pure linear fibrous stricture, especially if traumatic and occurring in patients who have never had gonorrhœa, may sometimes be radically cured by thorough longitudinal division of the stricture on the roof as well as on the floor of the canal, and by a maintenance of the cure for a moderate time by the occasional passage of very large sounds. I beg to reserve final opinion on this point for a future communication.

4. Inodular stricture does not seem to be radically curable by this method.

5. It seems possible that inodular stricture may be radically cured by a total excision of all the morbid tissue and suture of the healthy divided urethral ends; or, in cases where extensive loss of tissue makes such approximation impossible, by the transplantation (Wölfler's method) of strips of healthy mucous membrane derived from an outside source.—*Med. Record*, May 25, 1889.

Curran (F. G. A.) on the Treatment of Bubo by Aspiration and Pressure.—Being recently struck by the number of cases of suppurating bubo constantly under treatment in military hospitals, and the length of time which generally elapses before such cases, treated by the ordinary method of incision, are fit to return to duty, I have been led to adopt the following treatment, and, after a now somewhat extended trial, can confidently recommend its use. It possesses the following advantages: 1. As an operation it is not nearly so formidable to the patient, and, with the aid of cocaine, may be rendered painless. 2. There is no risk of scepticæmia. 3. The time under treatment is greatly lessened, being reduced, on an average, to about one third. 4. No after-cicatrix remains in the groin, which in many cases is a matter of no small moment.

Its mode of application is simple. As soon as fluctuation is detected, the pus is evacuated by a small needle, a pad of boracic lint adapted to the part, and the whole kept in position by a firmly-applied figure-of-eight bandage. The operation rarely requires to be repeated, and, afer the removal of the pad in two or three days, all inflammation and swelling will generally be found to have disappeared.—*Br. Med. Jour.*, May 11, 1889.

Tiffany (J. McL.) on Free Division of the Capsule of the Kidneys for the Relief of Nephralgia.—Four years ago the author had suggested the use of incision of the capsule of the kidney in the treatment of nephralgia. The patient, a woman, aged forty-nine, white, married. Had had gonorrhœa and syphilis. She had had abscess of the pelvis opening by the vagina, the discharge continuing for two years. Three years ago she experienced in the right loin sudden severe pain lasting for a moment. It was supposed to be due to passage of a kidney stone. The attacks recurred at irregular intervals, the periods becoming progressively shorter and the pain more intense. No calculi had ever been voided. Blood had been seen at rare intervals. The pain always began in the right loin midway between the pelvis and the ribs. It then extended toward the middle line of the body and

down to the bladder and groin on the right side. Exertion was apt to induce it. Pressure over the right kidney caused acute pain, but no tumor could be made out. The urine was moderately acid, sp. gr. 1.022, contained pus-cells and a few red-blood disks. There was no rise of temperature during the attacks.

The operation was performed January 12, 1889. The kidney, when exposed, moved freely during respiration. A deep stellate scar existed in the kidney, two inches from the lower end. No other abnormality was discovered. A sound was passed into the pelvis and a systematic exploration made, but no stone was detected. The capsule was then freely slit open for three inches. The edges of the cut gaped widely. The wound was then closed and an aseptic dressing applied. No urine passed by the lumbar wound. This soon healed and since the operation, a period of four months, there have been no attacks of nephralgia.—*Med. Record*, May 25, 1889.

Cheever (D. W.) on Sarcoma of the Tonsil—Excision.—The patient, a male, aged fifty-seven, single, for one year had to breathe through the mouth on account of enlargement of the left tonsil. No pain was experienced until November 1, 1888, when he "caught cold" and the tonsil swelled considerably and became sore and tender, and discharged spontaneously a few days later. At the same time he noticed some enlarged glands in the left neck. The glands gradually increased in size. The tonsil caused no more pain but there was an increasing sense of fulness behind it, increasing dysphagia and difficulty in articulation. There was loss of appetite and weight. When he came under observation January 14, 1889, the left tonsil was found to project nearly to the uvula, and was as large as a pullet's egg. There were two glands in the left neck each as large as a horse-chestnut.

The operation was performed January 17, 1889, ether being given, and the patient being in a sitting posture. A gland in front and one behind the sterno-cleido-mastoid muscle were removed. The first incision was semi-lunar, concave upwards, marking the boundaries of the digastric triangle. A second incision over the lower jaw at right angles to the middle of the first incision was then made. The right hyoid muscle was now divided and the other tissues pushed to one side. The lower jaw was then sawed in two in front of masseter muscle. The tumor was pressed out by finger in the mouth, and was found to be covered with a delicate capsule. On puncture a soft material exuded. The tumor and capsule were removed without great difficulty. There was no hemorrhage and the facial artery and external jugular veins the only vessels ligatured. The wound in pharynx was not sewed; the jaw was wired, the external wound in skin was wired; the external wound in skin was partially approximated and washed with two per cent. boracic acid solution, and dressed with boracic gauze. The wound was dressed daily. Healing took place rapidly, with no unfavorable symptoms. On the 30th day the wire was removed and the jaw found to be firmly united. Microscopical examination showed the growth to be round-cell sarcoma.

April 27th a second operation was performed for a tumor on the same side of the neck. The throat, however, remains healthy. A large glandular mass was removed from anterior carotid triangle. This also proved to be a round-cell sarcoma.—*Jour. Am. Med. Ass'n*, May 25, 1889.

Laparotomy for Hernia at Birth.—Dr. Phaenomenoff, of Kasan, performed this operation, which, as he admitted, had been once performed already. The pioneer of this bold proceeding was Dr. Dunlap, of Springfield, Ohio. In 1887 he attended the birth of an infant which had an umbilical hernia including the whole of the intestine from the duodenum to the sigmoid flexure. The gut could not be reduced owing to the narrowness of the neck of the sac and the contracted state of the abdominal cavity. The abdominal walls were therefore incised and the intestines replaced; the parietes were then sewn up. No anæsthetic was given, and the infant did not suffer from shock; it made a good recovery. Dr. Phaenomenoff's case also proved successful. The infant was born with a sac or swelling the size of a goose's egg over the umbilicus, the cord passing directly into that swelling. The walls of the sac were transparent, and through it the intestines could be plainly distinguished. The cord was ligatured and divided about four fingers' breadth above the growth. The infant was placed under chloroform about

sixty minutes after birth. Simple incision of the hernial sac was found insufficient, so the abdominal wound, made a little to the left of the middle line, so as to avoid the umbilical vein, was enlarged. It was then found that the intestine at one point was intimately adherent to the wall of the sac. The adherent portion of the sac was completely cut away, so as to be left on the surface of the gut. Reduction of the hernia was then effected with perfect ease. The contents of the abdomen were carefully protected, and then the entire sac was cut away close to its neck. Four deep silk sutures, passed through the peritoneum, and three superficial sutures were introduced to close the abdominal wound; they were removed on the eighth day. The infant made a good recovery. Dr. Stolypinsky reported the case in the *Centralblatt für Gynakologie*, No. 11, 1889. He believes that it represents the first instance where a child so young has been anæsthetized.—*Br. Med. Jour.*, May 11, 1889.

Tims (H. W. M.) on Reduction of a Strangulated Femoral Hernia after the Use of Ether Spray.—In a woman of eighty I found a hard swelling about the size of a large walnut lying over Poupart's ligament and to the outer side of the pubic spine; there was no impulse on coughing. I applied the taxis, but was unable to reduce it. I ordered the application of ice, and returned about 11 A. M. The patient was then feeling very ill; vomiting had set in, but was not stercoraceous; the tongue was furred, and she complained of abdominal pain and great thirst; the pulse was quicker, very feeble, and intermittent; the bowels had not been moved, nor had she passed any flatus, though there was constant eructation. I again tried the taxis, and failed. At 1 P. M. I saw her in conjunction with a medical man in the neighborhood, and he, too, was unable to effect a reduction. I considered the advisability of putting her into a warm bath, but decided against it on account of the patient's age and condition. The alternate application of heat and cold was then tried, and I saw her again about 6 P. M., by which time the vomiting had become incessant and stercoraceous, and the abdominal pain and tenderness great. I advised an operation, but she would not hear of it. On seeing her again about 9 P. M., it occurred to me as a last resource, as the application of ice was often of great advantage, to try the ether spray, which I did, spraying the hernial tumor till there was no tenderness on manipulation, and, to my great relief, I found I was then able to return the mass quite easily. The patient passed a good night, and is now quite recovered.—*Lancet*, April 27, 1889.

Warren (J. C.) on the Early Diagnosis of Morbid Growths.—Reference was first made to the great desirability of some means of making an early diagnosis in cases of possible malignant disease. The attempt to make a microscopical examination of morbid growths before their removal dates back to the earliest period of microscopical histology. The pain and danger of inflammation attending the methods adopted led to their abandonment. Antiseptic surgery, however, now enables us to perform such an operation almost with absolute certainty of absence of inflammation. Local anæsthesia, with either spray or cocaine, renders the exploration free from pain. The instrument which the author employs consists of a small canula sharpened at the end. The calibre of the instrument varies from two to five millimetres. The instrument is used by gently rotating the canula between the fingers. After the instrument has penetrated the tumor to the desired depth, it is withdrawn a short distance, and then entered obliquely, so as to cut off the column of tissue. The piece removed may be as large as five millimetres in diameter and three centimetres in length, or even longer. The fragment can be at once examined by means of freezing microtome, or placed in alcohol and hardened. The operation can readily be performed at the physician's office, and immediate diagnosis made. Several cases were reported, illustrating the information obtained by the use of the canula. The instrument has been used in over one hundred cases, with little or no discomfort to the patient, and with satisfactory results. It has been used in abdominal tumors. It has been used in one or two growths involving the abdominal parietes and peritoneum, but not in deep-seated organs. The object of the author in bringing the results of his observations before the Association was to show that modern improvements have made an old and discarded method not only practicable, but a valuable addition to our means of surgical diagnosis.—*Med. Record*, May 25, 1889.

Daily (R. T.) on a Case of Tolerance of Foreign Body in Trachea for 14 Months; Operation; Recovery.—On January 27, 1888, while sucking a beef rib, a child of ten months, "sucked" into the trachea a spicula of bone, irregular in shape, with sharp, jagged edges, about six lines in length by four lines in width, 1-32 of an inch thick. The immediate result was spasm of the larynx very severe, but tolerance was established, and for fourteen months the symptoms were: difficult *inspiration*, croupy cough, only varied in *degree* during an exacerbation of the symptoms (which exacerbations were frequent). The child could not sleep, being obliged to make use of the voluntary muscles to overcome difficulty of *inspiration*. Child became greatly emaciated.

On March 27, 1889, I performed laryngotracheotomy, and found the piece of bone just below the larynx in the trachea, and inasmuch as the symptoms were so constantly the same am inclined to think the bone never changed its position during the entire time (fourteen months).

My little patient has made a good recovery and is now almost well.—*Omaha Clinic*, April, 1889.

MEDICINE.

Kalindero and Babes on Lesions of the Posterior Spinal Roots and Spinal Cord in Addison's Disease.—In an autopsy upon a case of Addison's disease the authors found a chronic sclerosis of the cord limited to the region of the entrance of the posterior roots, and also a neuritis of these posterior roots themselves. This neuritis is characterized by a swelling of the axiscylinders, which are broken in places, and by a multiplication of cells. These lesions were most marked in the lower dorsal region.—*La France Médicale*, Feb. 28, 1889.

Pepper (W.) on Varicose Aneurism of the Arch of the Aorta.—The patient was a Chinaman. Hard-worked and exposed to cold and damp, was taken with sharp pains in the chest, oppression, and some cough, quickly followed by a livid, œdematous swelling of the face, neck, arms, and trunk down to base of chest. Careful examination excluded renal disease. No œdema of legs nor organic disease of lungs. Over the chest on both sides were clusters of greatly dilated, tortuous veins. The heart seemed healthy, and the radial pulses were equal. There was dysphagia, shortness of breath, and anorexia. The voice was weak and husky. There were no external tumor nor enlarged glands. There was a constant musical venous hum in the first and second intercostal space. Two days before death the murmur disappeared.

At the autopsy there was no œdema below the waist. Profuse venous oozing on cutting through the skin of the thorax. All the tissues in the anterior mediastinum were highly œdematous and matted together. The pericardium contained one ounce of somewhat bloody serum. Upper part of pericardium somewhat roughened and granular. Heart of medium size. Tricuspid and mitral valves normal. Right auricle enlarged and its walls somewhat thickened. Inferior vena cava admits two fingers up to the first joint. Superior cava admits an index finger to the second joint, and there the finger becomes tightly compressed. Aortic valves normal, aorta a little dilated. One and a half inches from aorta valve is an opening on the posterior aspect of the convexity of the arch, one inch in diameter. This opening leads into an aneurismal sac projecting backward and to the right, and of the size of a small orange.

The tissues around the sac are thickened. It is bounded on the right by the right lung, which it compresses; posteriorly it lies on the right bronchus and adjacent structures. At the junction of the right internal jugular and subclavian veins, behind one of the valves, is a globular thrombus. The sac is filled with blood-clots which are not laminated. The aneurism had begun to cause absorption of the cartilages of the trachea. The superior cava much thickened and compressed by the aneurismal sac. At this point the superior vena cava does not admit the tip of the little finger, but a probe passed in, enters directly into the aneurismal sac.

The aneurism laid open shows an irregular erosion into the inner wall of the superior vena cava, three fourths of an inch in length. The edges of this opening are not occupied by any clot. From the right auricle a probe also enters the aneurismal sac. The wall of the vena cava superior formed part of the posterior boundary of the aneurism for at least one inch. The openings from the aneurism into the aorta and the vena cava are both elliptical. The

œsophagus is tightly adherent to the aneurism and seems to be compressed.—*Med. Press West. N. Y.*, May, 1889.

Hare (H. A.) on Aspergillus of the Anus.—The patient was a child of four, with pneumonic consolidation of the lower lobe of the left lung. Brandy and digitalis in small doses and quinine in suppository by the rectum were ordered. While examining the child's chest the following day, the mother informed me that the anus was so sore that defecation seemed impossible, and that this complication had come on chiefly since his last visit, having existed only to a moderate degree beforehand. On examining the anal opening I found no raw surface exposed to the eye, but extending from the centre of the closed sphincter for half an inch on each side was a peculiar downy growth, rather dark in color and closely resembling the ordinary mould seen on vegetable material which is stale and about to undergo decomposition. Removal of this even in very small amounts caused a great deal of pain and left a small bleeding spot behind it.

Careful examination of this growth showed it to be that of *aspergillus fumigans*, the mycelium ending in the thick flask-shaped enlargement which was covered by the cells of *basidia*. Even the chains of spores were well marked.

On two pieces of sterilized potato I got growths. On the first the growth was not *aspergillus*, but on the second in was identical with that taken directly from the child; the peculiar corrugations of the growth after limitation by the edges of the potato being very marked aside from the microscopical appearance. A micro-photograph could not be obtained owing to spoiling of the specimen by careless hands.

The anal opening of the child is still slightly raw, but is much improved under the use of a wash made up of a weak carbolic acid solution.

The cause of this curious case is not apparent. One would imagine that the quinine suppositories would have been germicidal to any growth, and they can hardly be thought to be the cause of the presence of the fungus. Up to the time of the onset of pneumonia the child had been a picture of health.

The sanitary surroundings were exceedingly bad. Directly behind the house was a large pool of stagnant water giving off a wretched odor, and into which much of the drainage flowed. The condition of this child and the other children, personally, was, however, all that could be asked of persons living in such poor circumstances. —*Univers. Med. Mag.*, June, 1889.

Keefe (D. E.) on Two Cases of Irregular Œdema Complicating Malaria.—At 2.30 P.M., April 20th, I was called to a domestic, aged twenty-four. Found her extremely restless, had a chill previous to my arrival and complained of nausea and vomiting; left-hand wrist greatly swollen, pitting on pressure, as were both ankles also; temperature 104½°, pulse 110, pain in head, back, and limbs; had been told she had dropsy, which greatly frightened her. Urinary examination proved negative, as did physical examination of chest and abdomen. By exclusion, therefore, as well as the general severity of the onset, I was forced to the conclusion that I had malaria of the tertian type to deal with. I accordingly gave quinine in antiperiodic doses, and was pleased to find a ready response. There was no return of the paroxysm and she returned to her work in a few days. If there were any doubt as to the correctness of the diagnosis it was speedily dispelled; for in about six weeks I was again called and found her suffering from a similar attack, only that the œdema was limited to one hand and wrist. The second attack yielded to the same treatment employed in the first, and she has to this time remained in good health.

The second case was a Swedish woman age thirty-eight. Has resided for a year in an intensely malarious district. In common with her husband and four children she had suffered from several attacks of tertian malaria. The disease had always quickly responded to treatment, and with the exception of a slight amount of anæmia, she was in her usual health. I was called to attend her the last time, not for malaria but œdema under the eyes and of the right arm and wrist. The arm was somewhat painful. Although the eyes and arm were all she complained of, upon inquiry it was elicited that she had occasionally chilly feelings along the spine and vermicular movements and weakness of back and limbs, with head and backache. Physical and urinary examinations were made and proved negative. As in the previous case I diagnosed malaria and ordered a thirty-grain dose of quinine on the first day, and nine grains with iron and arsenic daily for ten days. The

œdema and all other sypmtoms disappeared in three days.

While I did not pretend to be able to explain how malarial poison acts on the organism to produce such exudations, I would suggest that it is due to the poison of the disease acting on the nerve centres, just as urea acts in kidney diseases, and through the sympathetic ganglia paralyzing the vaso-motor nerves, thereby dilating the arterioles and thus causing an afflux of blood to one part. In other words it causes an inco-ordination on the part of the vaso-motor nervous system. This superabundance of blood the veins of the part find it more than usually difficult to return to the circulatory centre, in consequence of the congestion existing in nearly all the important viscera and consequent pressure on and narrowing of the lumen of the veins and lymphatics passing into and through them. For these reasons stasis and transudation are encouraged and produced.—*Boston Med. and Sur. Jour.*, May 16, 1889.

Skin Varnishing in Man and Animals.—Some interesting experiments were recently made by Dr. Tecontjeff, of St. Petersburg, on the effect of applying a varnish, impermeable to air, to the skin of human beings. They were carried out on twenty-three healthy persons, six of whom were anointed with an irritating pomade, eight were covered with a gelatinous compound, and nine with a mixture of diachylon and lard. Eighteen of the subjects were adults, and the remaining five were youths between twelve and fifteen years of age. For some time prior to the experiments careful observations were made as to temperature, respiration, sensibility, and the cutaneous reflexes, the body weight, and the excretion of urine. They were then placed in the recumbent position, and the entire body covered with the composition five times in the twenty-four hours, excepting the head, and in some instances the palms of the hands. The material was left on for from two to seven days. At the same time the skin of three rabbits was likewise covered with gelatine or diachylon. These animals died in from two to seven days with the characteristic symptoms following varnishing of the skin in animals. Although the experiments were carried out on individuals of different ages, different constitutions, different habits, and at different temperatures, none of the symptoms which followed varnishing in animals were observed. The appetite and the intestinal functions were unaffected, and the subjects expressed themselves as feeling perfectly comfortable, especially those who were covered with the gelatinous mass. Some diminution of sensibility was noticed, accompanied by complete prostration—a point which scarcely bears out the assertion as to their feeling comfortable. The author concludes that in man, contrary to what obtains in animals, varnishing of the skin entails no tangible risk, at any rate for any any period of time likely to be required for therapeutical purposes.—*Med. Press*, May 15, 1889.

Endo-Auscultation of the Stomach.—Dr. Carlo Giorgeri has recently described[1] an addition to the methods of physical examination at present in use, of which a short preliminary account was given by Professor Aurelio Bianchi at the Medical Congress held at Rome, in October, 1888. That gentleman, on passing an œsophageal tube into a patient's stomach, and applying his ear to the upper end, heard various sounds as the instrument travelled down the gullet, and when its lower end was in the stomach. By fixing a bifurcated, gum-elastic tube provided with ear-pieces like those of a binaural stethoscope to the upper end of the œsophageal sound, he contrived an instrument with which he was able to practice what he calls "endo-auscultation," both of the œsophagus and the stomach. Dr. Giorgeri divides the sounds heard in this mode of examination into (1) œsophageal, (2) gastric, (3) respiratory, and (4) cardiac. The œsophageal sounds are produced by the rubbing of the instrument against the walls of the gullet; they are loudest at the two narrowest points of the œsophagus, namely, at its upper aperture opposite the posterior surface of the cricoid cartilage, and at the cardiac orifice. There may also be one or more strictured portions where the sounds are heard with special intensity. Peculiar sounds are caused by abnormal conditions of the walls of the œsophagus, or by foreign bodies adherent to them; and gurgling may be heard if the instrument enters a diverticulum containing fluid or solid food. The sounds heard in the stomach are chiefly of a gurgling nature, or they may be caused by friction against foreign bodies or against the walls of the viscus altered

[1] *Gazzetta degli Ospitali*, March 27th and 31st.

by organic disease, or by sudden sharp contractions of the organ. The respiratory sounds begin to be heard as soon as the instrument enters the upper aperture of the œsophagus, and increases in intensity as it travels downwards, being most distinct a little above the cardiac orifice. If the walls of the stomach or œsophagus are the seat of strictural changes, the transmission of the breath-sounds is interfered with to a greater or less extent. The heart-sounds are heard from the middle of the œsophagus downwards, and in the stomach. The two sounds are distinct, but more blowing in character than when heard in the ordinary way. Professor Bianchi made some experiments on the effect of the introduction of fluid into the stomach on the sounds heard by endo-auscultation. For this purpose he modified the instrument, by fixing a bifurcated tube to the upper end of the œsophageal sound, one arm of which was of considerable length, and was fitted with a glass funnel at its free extremity, whilst the other arm was again bifurcated, the two ends being provided with ear-pieces as before. If, after introducing the instrument, fluid was poured through it into the stomach, the cardiac and respiratory sounds at once ceased, and could not again be heard, even on drawing up the œsophageal tube so that its lower end was above the level of the fluid in the stomach, whilst in the œsophagus itself the heart and breath-sounds were very indistinct. If the stomach was then emptied, and the instrument again introduced, some time elapsed before any sounds were audible. Professor Bianchi offers as an explanation of this curious effect that, as the vibration of membranes is more perfect the drier and more tense they are, the introduction of fluid impairs the vibratory power of the stomach walls. He believes that endo-auscultation may prove of great service in the study of diseases of the stomach and œsophagus, and possibly of the circulatory system in the thorax.—*Br. Med. Jour.*, May 18, 1889.

OBSTETRICS.

Winard (E. J. C.). Does the Menstrual Flow Originate in the Tubes? The Act of Menstruation Viewed from an Inverted Uterus.—Margaret, aged about thirty years, multipara; occupation a basket weaver; was delivered of a child five months before at term. The placenta was adherent, and the attendant pulled it away, leaving the vagina filled with a mass supposed to be a tumor.

When she applied to Dr. H. for treatment she was much reduced and very nervous. Upon examination the uterus was found to be inverted. Proper treatment was given, and when she was able a reduction was attempted, but failed because the patient refused to take an anæsthetic, and was too feeble to have it done without. She left the place, but returned a few days before my visit.

She came to the office complaining of hemorrhage. It was found that she had been menstruating for four days for the first time in five months, or before the birth of the child, and that she was flowing more freely than was her normal habit; had much pain, nervousness, and prostration.

Upon examination I found the diagnosis of inverted uterus to be correct. The left ovary filling Douglas' cul-de-sac, and the right one lodging above the ring formed by the neck of the uterus. The tubes were dragged down, and put on a strain in the sac formed by the peritoneal surface of the inverted uterus.

The surface of the tumor was of a dark-red color, studded with points of a darker hue, and resembled the tongue of a bad case of scarlet-fever, without the creamy coating.

From this surface no discharges to speak of could be wiped away with cotton; but from the tubes a dark healthy menstrual flow passed out drop by drop, and when the tubes were pressed upon would form a stream for an instant.

The openings of the tubes of this inverted uterus were dilated, so as to admit the head of a small uterine sound.

With treatment she recovered from this attack, flowing several days longer than usual, and I hope to hear further of the case from observations made at future monthly periods.—*Gaillard's Med. Jour.*, May, 1889.

Whitfield (D. W.) on Peripheral Neuritis Due to the Vomiting of Pregnancy.—The patient was a multipara of forty. Her previous pregnancies had been unattended with much discomfort. In this, her seventh pregnancy, vomiting commenced early, and became worse as pregnancy advanced. For a fortnight

almost nothing seemed to be retained. She lost eighty pounds in weight. A fortnight before delivery she felt her legs cold, and found she was losing the use of them; she had to be assisted up and down the stairs. She had no pain—only the feeling of coldness in the legs. She tried to obtain warmth in them by sitting before the fire, but in vain.

She was delivered of a fairly well-nourished female child at full term on August 7, 1888. Labor was quite natural, lasting about five hours. The vomiting ceased the day after, and she began to take nourishment. She had no rise of temperature, the lochia were normal, and it was thought she was doing well. However, after the fourth day she complained of her legs feeling numb, and a few days afterwards of severe pains in them, and of "pins-and-needles" in the hands, a burning sensation in the palms, and pains up the arms. She could move her legs slightly in bed, and the wrists did not drop until the twelfth day after confinement. On the thirteenth day we got her out of bed, and it was then that I saw the extensive nature of the disease. Dr. Dreschfeld saw her with me on this date, when we found she had almost lost the entire use of both arms and legs. She was unable to bear the slightest weight on her legs, and had difficulty in crossing one over the other. The patellar and other reflexes were absent; both feet were extended, and the toes flexed; the hands were dropped, the wrist and fingers were flexed, and she had no power to extend them. She had difficulty in raising herself in bed, and complained of a peculiar numb feeling around the lower part of the abdomen and epigastric region. The breathing fortunately was unaffected. There was pain on pressure over the main nerve trunks in both arms and legs. The cutaneous sensibility varied in different places—increased in some parts, diminished in others. We gave her liq. strychniæ, and employed massage, and in about a week she began to improve. The improvement has been slow but continuous, and at the present time the arms, forearms, thighs, and trunk are almost well, but the hands, legs, and feet are not. She cannot bear any weight on the feet as yet, although she can flex them and move them about more freely, and power is certainly returning gradually.

Of course peripheral neuritis may come on during any wasting disease, and very rarely after a confinement; but I am not aware of any case having been described which has been due to excessive vomiting during pregnancy. The question is whether, should the symptoms show themselves during an excessively sick pregnancy, it would not be a sufficient reason for inducing premature labor. In this case the early symptoms were extreme coldness of the lower limbs from the hips downwards, with partial loss of power, followed by a feeling of numbness.—*Lancet*, March 30, 1889.

Bernardy (E. P.) on an Unique Presentation of a Fœtus.—The patient who gave birth to this child was a primipara, aged eighteen years. I saw the case for the first time at 8 o'clock (April 8, 1889); the membranes had been ruptured four hours, the fœtus was presenting in the right oblique-diameter; the presenting part seemed to be the breech, the right side deeper in the pelvic cavity than the left; the fingers could be hooked in what appeared the groin, but did not have the full feeling one would expect in breech; a sort of sulcus or fissure was in the centre of the presenting part. Passing the fingers further upward, the bone of the skull was detected. I thought that I had a double pregnancy, the breech of one presenting and the head of the other imbedded in the chest of the first. External palpation showed the uterus divided in two by a deep dent in its fundus, a large body occupying the upper left portion, and a body occupying the lower portion of the right side.

I did not introduce my hand into the vagina, for the maternal parts (vulva) were rigid, and had not undergone any softening, and such examination would have undoubtedly caused a rupture of the perineum; the os was spasmodically contracted around the presenting part. The patient not having much pain, and having to deliver a hydrocephalic case, I left her for about two hours. On my return, the entire portion was grasped by the vulva, and the child was delivered in the following position. It will be seen that both shoulders presented fair and square, the neck, somewhat stretched, thrown forward on the chest, and the head slightly twisted sideways, lying in a cavity in the chest; the arms laid on the top of the chest, right and left side, and head between. There was hardly any pain connected with the confinement.—*Times and Register*, May 18, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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MEDICINE AND PATHOLOGY.

Black (J. R.) on Advantages of Substituting the Morphia Habit for the Incurable Alcoholic.—The question the author discusses is, if a person has got to the stage of abnormality that he cannot do without a pathological nutrient, particularly of the alcoholic kind, is it better to allow him to go on, or to endeavor to have him substitute morphine for it? After years of experimental trial and observation, he has arrived at the conclusion that the latter is immeasurably the best, or by far the least of the two evils. Some of the grounds for this conclusion are the following:

On the score of economy, the morphine habit is far the better. On the plea of respectability in appearance and behavior, the advantage is altogether on the side of the morphine-eater. There is no strong liquor odor of the breath, no swollen, red, and turgid face, no staggering gait, no violent language and conduct, in the case of the morphine-eater. All that is apparent, even to the trained eye in the latter habit, is a pale, sallow skin, a somewhat wasted body, an introspective wandering eye; and, when under the full influence, a somewhat childish exhilaration, followed by a dull and dreamy stupor.

This brings us to the most striking divergency in the effects of the two agents, to wit, that on the animal passions, such as rage, cruelty, revenge, and reckless, daring deeds of crime while under the influence of alcohol; and to the quieting, soothing effects upon the same passions, of morphia. The former rarely fails to arouse the combative, destructive, and unfeeling brutality in a man's nature, while morphia seldom shows any effects of the kind. Alcohol, carried to inebriation, stupifies the higher brain faculties and excites the lower; while morphia, if any thing, carries its soothing exhilaration quite as powerfully to the lower propensities as to the nobler aspirations.

The morphine habituè is hardly ever a brawler, a disturber of the peace at home or on the street; he is not ready to use, on slight provocation, the bludgeon or the knife on others; in his family circle he may be indifferent, but he is not cruel, malicious, and devilish. A correct outline of the two pathological agents on brain-function may be studied in the low saloon, and in the opium-smoker's den. In the latter all is quiet; there is a stolid indifference of one to the others; they are either wrapped in a state of ecstasy, or buried in profound sleep. In the saloon nearly all are noisy, boisterous, and chattering; what one says to another often raises a quarrel in a moment; blows are exchanged, friends take sides, and soon all are struggling and raving like maniacs; the police are called, blood is flowing freely, maybe one is dangerously cut, and the remainder are taken to prison. Who ever hears of such scenes in the opium-smoker's den? The same contrasts of scenes in miniature are enacted by the inebriates and by the opium eaters, respectively, at their homes.

If men must have stimulants, if the craving for them is, as many falsely aver, a normal trait, then let the devil-let-loose

alcohol alone, and substitute the quieting, somniforous morphine in its place. In this way the so-called want will be filled peacefully, far more harmlessly, economically, and without those displays of brutal ferocity that are so often seen under alcoholic sway.

There are yet other advantages of the opium over the alcoholic habit. So far as the production of disease is concerned, the latter is far more prolific than the former. In common with other observers, I have frequently noted that comparatively delicate persons who have been addicted to opium for many years, have very good health, or at least are not victims so often as steady liquor drinkers are to serious attacks of disease. It takes a great deal of vital endurance to be constantly under the influence of alcohol for ten, twenty, or thirty years, and not seriously sacrifice health or lose life at some period of the interim. How much better off, then, is the opium devotee when this can be done by delicate persons for like periods without engendering serious disease! The greater number of those who die from the opium habit do so by taking an over-dose; while the spirit-drinkers bring on themselves delirium tremens, cirrhosis of the liver and kidneys, with fatty degeneration of the tissues, which, when occurring, as it is very apt to do, in the vascular system, leads to sudden death. No medical writer has, nor, in fact, can, truthfully attribute such a list of equally fatal maladies to the opium eaters as can be attributed to the spirit consumers; and if it be desirable, as it is, that a loved one may be preserved as long as possible to his family circle, with all his faults—and who is there without them—then the preference on the score of health and length of days should by all means be given to morphine in lieu of alcohol.

There is still another advantage of the opium habit over that of the alcoholic that deserves mention. It is a familiar generalization that the habitual use of ardent spirits has often a most disastrous effect upon the qualities of the children procreated, and especially upon the structure and functions of the nervous system. A nervous system in a man or woman somewhat shattered by drink cannot transmit that which he or she has not, to wit: a strong, healthy and well balanced neurotic temperament. The same may be said of the opium habituè. But, fortunately, in the latter case nature comes to the rescue in the way of prevention, that is by promptly rendering the opium-eater sterile. The same occurs, but much later, with the inebriate, so that the sins he can bring by this delay upon the children—to the third and fourth generations in millions of instances—become among the most melancholy and fearful that can befall a sensate being.

The evidence of the sterilizing effects of opium is not sufficiently frequent in our land to attract attention, but in foreign countries it is much better known. In the Encyclopædia Britannica, vol. xvii., p. 793, it is stated that in Orissa one in every twelve or fifteen are opium eaters, and that the moderate use of it may be indulged in for years without any appreciable ill-effects, except weakening the reproductive powers, and that the average number of children of opium eaters is 1 : 11 after eleven years of married life.

There is a striking appropriateness in this effect in securing the survival of the fit. If a person is so constituted that he cannot control his animal desires by the faculties specially designed for the purpose, and so renders himself more or less miserable and diseased thereby, is it not well that he should be rendered impotent, and so fail in propagating others like him? By this provision the road, by abuses and dissipation, to extinction is immensely shortened; the world is not cumbered by new crops of unbalanced wretches to whom life is a curse, but the whole is very nearly avoided by prevention, or by the expedient of sterilized sexuality.

On the score, then, of a saving to the individual and his family in immediate outlay and of incurred disability, on the great diminution of peace disturbers and of crime, whereby an immense outlay will be saved by the State; on the score of decency in behavior instead of perverse deviltry, of bland courtesy instead of vicious combativeness, of quiet gentility instead of cruel destructiveness; on the score of a lessened liability to fearful diseases and the lessened propagation of pathologically inclined blood, I would urge the substitution of morphine instead of alcohol for all to whom such a craving is an incurable propensity. In this way have I been able to bring peacefulness and quiet to many disturbed and distracted homes, to keep the head of a family out of the gutter and out of the lock-up, to keep him from scandalous misbehavior and neglect of his affairs, to keep

him from the verges and actualities of delirium tremens horrors, and, above all, to save him from committing, as I veritably believe, some terrible crime that would cast a lasting and deep shadow upon an innocent and worthy family circle for generation after generation. Is it not the duty of the physician, when he cannot cure an ill, when there is no reasonable ground for hope that it will ever be done, to do the next best thing —advise a course of treatment that will diminish, to an immense extent, great evils otherwise irremediable?

In preferring the alkaloid morphia to the crude opium for the purpose named, I am but in accord with authorities as to its advantages.

There is usually little trouble in effecting the act of substituting morphia for alcohol, but it is best done under certain precautions, one of which is not to let the inebriate purchase or portion out the morphine himself. The wife, mother or daughter should do this, keeping it meanwhile under lock and key. The morphine should be dissolved in half-grain portions to a tablespoonful of liquid—preferably an aromatic elixir—and given three, four or six times a day, according to the exigencies of the case. It is well to begin with the minor amount per day, cautiously increasing the dose from year to year, in order to only soothe sufficiently the shattered nerves. The alcoholic victim will soon learn, under a little care and persuasion, to pass the saloon by without difficulty and to hurry home, where he knows that that can be obtained which will lift him from the horrors to the dominions of bliss.—*Cincinnati Lancet-Clinic*, May 11, 1889.

Bowditch (V. Y.) on Two Cases of Phthisis Treated by Intra-Pulmonary Injections.—The fluid most used in these cases was that known as "carbolized iodine," of which the formula is as follows:

℞	Sulphate of atropia	gr. ¼.
	Sulphate of morphia	gr. ii.
	Tincture of iodine	ʒ iii.
	Carbolic acid	gtt. xx.
	Glycerine	ʒ iss.
	Twenty to 30 % alcohol . . .	ʒ iss.

About 15 minims formed the average dose.

The result in these two cases is thus summarized by the author.

Synopsis of first case: Man, aged twenty-four, with phthisical family history, suffering with an acute phthisical process in the right lung; severe cough, fetid expectoration, increasing emaciation and loss of strength. Immediate improvement in all the symptoms after one intra-pulmonary injection in the right apex, the same phenomena occurring after three subsequent injections in an interval of three months. Complete arrest of disease and renewal of health for four months. Sudden appearance of tubercular disease in left lung at the end of this time. No apparent relief from three injections into left lung. Rapid failure up to present time.

Synopsis of second case: Man, twenty-six. Acute and far-advanced case of phthisis. Evidence of large cavity at apex of right lung, with general infiltration below. Very great relief from severe cough and expectoration by two injections into the right apex at an interval of a week. Marked change in the physical signs at the point of injection within a few hours after operation. Death three and one-half weeks after entrance.

In the first, I do not think there is a shadow of a doubt in the mind of any of those who saw the case that the injections were the chief cause of the arrest of the disease during the patient's first stay in the hospital last year. The almost immediate disappearance of the most distressing symptoms, and the equally apparent improvement in the general condition after each of the four injections, were quite sufficient to have convinced the most sceptical as to the efficacy of the treatment at first, even though, four months later, disease appeared in the other lung, and the same treatment seemed to fail in the desired effect.

As to the second case: the extraordinary change in the physical signs shortly after the operation, showing a drier condition of the cavity in the right lung, and the marked relief from the most harassing cough and loss of sleep, were such that in any similar case I should most unhesitatingly advise the same treatment, even had I no hope of a permanent cure.—*Boston Med. and Surg. Jour.*, May 9, 1889.

Hinsdale (G.) on Epilepsy from Peripheral Irritation.—The first patient was a man of forty-three. On Feb. 17th, 1888, a bale of hay fell on him from a height of ten feet. The chief violence of the blow fell on the right hip, the right hip being broken. The patient was unconscious for half an hour. From the start it was noticed that the left testicle had been forced out of its position. On the

eighteenth day he was seized with sharp pain in the left groin and scrotum, and he noticed weakness and loss of sensibility in the left side, with some dizziness in bed.

All bad symptoms grew worse, and epileptiform attacks set in, the first occurring on the sixtieth day after the accident. At this time he began to have a painful cramp in the left side. As the patient expressed it, the heart seemed to be squeezed, and there was pain in the chest extending up to the left occipital region. He says that he heard a roaring sound ; he then fell back in bed unconscious. Those about said he seemed to stop breathing. He was pale at first, and after a few moments began to contract his left side.

There was no violent movements, but he thinks that from what others said his left arm and side became rigid. He ground his teeth, but did not froth at the mouth or bite his tongue. He did not pass urine. He made no outcry as the attack came on. Duration of first about one minute.

About May 23d the duration of the convulsions was two and one half minutes. In all the attacks both eyes twitched, and the face gradually became red and bluish and swollen. He always felt drowsy after an attack, and generally slept one fourth to one half hour, but would wake up with more severe pain in the back. Always had an *aura*—pain up left side. Sense of contraction in the left groin ; then a strange feeling about the heart, as though about to faint ; dizziness in the head ; no noises in the ear.

December 8th, 1888, he had seventeen attacks. These all came between 2 and 3 P. M. and at night. His friends say that he turned and twisted about, totally unconscious, taking long, deep breaths. He was raised up for fear of smothering. The patient says he has had in some attacks a dim consciousness of what is going on. This only in the less severe attacks. He thinks that he has heard remarks made. It is said that his hands became clenched, and about the same time both legs became rigid. His face turns red and he grinds his teeth.

His condition on December 7th, 1888, was as follows : Cremasteric reflex present on both sides, but less on the left than on the right. The right testicle hangs lower and is of normal size. Left testicle about one-third size of the right ; softer. Scrotum was never swollen. Pressure on the left testicle gives pain, which, rising to the left side of head, resembles the aura which precedes his attacks, but has never caused a spasm. Pressure below the inguinal canals more painful on the left side. No pain in penis. Has had only about four erections since the injury. Never has had sexual connection since accident. Thinks he could not, and thinks it would be too painful. The inguinal regions appear as usual. Pain in sacral region. Gait slow, but otherwise normal. Station normal. Knee-jerk, right, normal ; left, diminished and easily exhausted. Abdominal reflex equal on both sides and easily excited. Heart and lungs normal. Pulse 64 ; rather feeble. Stomach and bowels in good order. Never had any venereal disease. Sleep wakeful. Dreams occasionally. Has dreams while half awake, at this time has tingling. General health is good. Has not lost flesh. Urine passed three or four times in twenty-four hours ; has never been able to make it standing, though he has tried half an hour ; reaction normal ; specific gravity, 1015 ; no albumin. Eyesight growing poor in left eye since he was hurt. Two months after the injury he began to see objects double, and shortly afterward as many as half a dozen images instead of one. He has this symptom every day to some extent. Pupils large ; react to both light and accommodation. Left more sensitive to light. Ophthalmoscope shows rather pale fundus ; otherwise normal. During his stay at the hospital he had most violent daily fits, always before 8 A. M.

Dr. William Hunt removed the testicle on December 29th, 1888. Just before the first incision the patient had a distinct fit. Just before the cord was cut another fit began, but section of the cord caused it to cease. Under the microscope atrophy of the glandular structure was demonstrated. Over three months after the operation there had been no convulsion or aura. The left side regained strength and sexual power became normal, the only disability being a weak back.

Dr. Weir Mitchel, from memory, recalls the following case :

" Many years ago, I was called upon to see a blind girl about seventeen years of age, who was afflicted with epilepsy. The attacks were violent, so that she bit her tongue. After each attack she became unconscious and remained so for some hours. The attacks came on at intervals of not less than two days, and were increasingly fre-

quent when first my attention was called to the condition. The girl was of rather weak mind, and had the history of a fall upon the head, to which the attacks had been attributed. A very careful examination revealed the fact that she had a purulent discharge from the left nostril. In the effort to treat this it was discovered that that side of the nose was completely occluded by a foreign body. This was extracted piece by piece, and was found to be a bean, which, in some foolish play, had been pushed up the nostril and lodged there. It had at one time begun to sprout, but this growth had manifestly been arrested by circumstances unfavorable to its increase.

"The removal of the bean and washing out of the nostril with proper astringent solutions resulted in complete cure of the fits. As I remember it, she had one or two after the removal of the foreign body, but no more. These attacks were most positively of an epileptic nature, and they had nothing about them of hysterical quality. They had long been considered incurable."—*Am. Jour. Med. Sci.*, June, 1889.

Mortimer (J. D.). Is "General Paralysis of the Insane" Necessarily an Anomalous and Hopeless Disease?—As types of cases which puzzle the practitioner and cause the above question to be asked, the author cites four examples:

1. A big man, aged thirty-two; much alcoholic and sexual excess. Boisterous excitement, varied by emotional depression. Says repeatedly that his brother has millions, and he himself can have as much as he likes. Pupils equal; knee-jerk brisk; tongue tremulous; slight slurring of syllables. He recovered in six months, and has had no relapse (two years).

2. A temperate man, aged forty-five: hard worker and keen politician. Stupor, with slight indications of general paralysis. Well in six months and returned to work. Readmitted "a typical general paralytic" three months later. Died, worn out, after a few weeks' intense excitement.

3. A man, aged thirty-eight; irregular life and recent domestic calamity. Extremely ill; large syphilitic ulcers; sores; tongue raw and tremulous; pupils unequal. Sleepless and restless, shouting that he is worth millions, the greatest man in the world, etc. In two months there was general improvement; no delusions, slight emotional depression; still tremor and unequal pupils; retinæ healthy. Discharged in four months, being quite rational and intelligent; knee-jerks a little brisk; no tremor or inequality the last six weeks.

4. A man, aged thirty-one, after some eccentricities, became maniacal, with much emotional exaltation, extravagant boasting, letter-writing to the Queen, masturbation, self-decoration with trumpery, etc. As this subsided (after close on two years) he became taciturn and hypochondriacal with loss of expression, thickness of articulation, fibrillar tremor, and incapacity for exertion. These threatening symptoms gradually vanished, and since (nearly three years) he has been in constant and responsible employment.

The author thinks that acute disorders of the central nervous system, not essentially different from one another, may be induced by a variety of causes, toxic and otherwise, acting singly or in combination; and in subjects so predisposed by age, sex, general constitution, etc., these are apt to be associated with progressive and general degeneration.—*Lancet*, March 16, 1887.

Leviseur (F. J.) on Irritation and the Treatment of Ringworm of the Scalp.—Ninety-eight children were affected by the disease, which presented itself mostly in its chronic form. There were four or five cases of so-called irritated ringworm and two of true kerion. In age the children ranged from six to fifteen years. Microscopical examination showed the presence of the fungus in the scales and hairs taken from the heads of the most of the patients. Treatment was begun in the following manner: The hair was cut short with a pair of scissors close to the scalp and some of the affected spots carefully epilated. It is absolutely necessary, I think, that the physician himself, or an experienced nurse, practise epilation. To leave this important part of the treatment to a hand untrained for the purpose not only recalls to mind the cruel times of "calotte" by its being very painful, but is also the source of much undue irritation, which it is very important to avoid, as I have said above.

A lotion consisting of simple tincture of benzoin and bichloride of mercury, in the proportion of one to three hundred was then applied all over the scalp.

A soft nail-brush was used for this purpose, and the lotion brushed into the scalp

quite vigorously. The length of time and the mechanical force consumed in this process was modified according to the condition of the normal and diseased parts of the scalp.

The nurses were instructed to wait until the irritation set up by this measure had disappeared, and then apply daily a salve of ten per cent. of salicylic acid with vaseline as a vehicle. As a rule, the irritation had passed away the next morning and the salve could be used. If, however, the irritation persisted, or even postulation occurred, the scalp was left entirely alone till these symptoms had disappeared. I selected the vaseline as a basis for the salve, in preference to greasy matters, because the latter are liable to become rancid and consequently irritating beyond control.

Epilation followed by the application of the lotion was repeated in the same manner in intervals of a week. I gradually increased the strength of the lotion, as well as that of the salve, till the former reached two to three hundred and the latter twenty per cent. It was astonishing how quickly the disease yielded to this treatment and the symptoms of irritation or inflammation disappeared. Whenever a case seemed to be cured treatment was suspended for a fortnight and the patient discharged if no sign of disease had reappeared. From time to time the discharged children were examined again. I began treatment in the commencement of October, and at the end of February nearly half of the number of patients were cured.—*Med. Rec.*, June 1, 1889.

"**Malta Fever.**"—Under this name our English confrères are struggling with, what appears from their description, to be the same disease as our old southwestern enemy—typho-malarial fever.

The disease declares itself gradually, with headache, sleeplessness, loss of appetite, and thirst, often without shivering or diarrhœa, and without spots. Symptoms of this kind, with more or less severity, last for three or four weeks, apparent, but deceptive, convalescence then usually sets in, to be followed in a few days by a relapse, with rigors, intense headache and fever, with, frequently, diarrhœa. In this state the patient may continue for five or six weeks with more or less delirium. Improvement again sets in, to be followed, it may be, by another relapse in about ten days or a fortnight, with shivering, headache, sleeplessness, great debility, with night sweats, pains in the hips, knees, ankles, and elbows, and often in one or both testicles. Again, the patient enters on a state of convalescence, which may last for a month or six weeks. The old symptoms may again appear with extreme debility, a thickly-coated tongue, with thirst, a temperature ranging from 105° F. in the evening to nearly normal in the morning, with night sweats bringing no relief to the general distress. The rheumatic symptoms are the most constant and the most distressing; all the joints, large and small, may suffer. Dr. Veale describes cases in which the intervertebral joints, especially those of the lumbar region and the sacro-iliac synchondroses, were so severely affected that the patient "dreads every movement; he will lie for days in one position, risking the formation of bedsores, and resisting the desire to evacuate his bowels rather than encounter the suffering that a movement will entail. Oftentimes the tendo Achillis and the fibrous structures around the ankle-joint are involved; but perhaps the lumbar aponeuroses and the sheaths of the nerves issuing from the sacral plexus are still more commonly affected."

The most prominent peculiarities of this remarkable fever are: first, its tendency to relapse again and again when convalescence seems fairly established, yet without the other symptoms of the form of fever known as "relapsing"; secondly, its extraordinary duration, often extending over months; thirdly, the variety and severity of its complications, more particularly in the rheumatic symptoms, which are present in a very large proportion of the cases.

It must be confessed that as yet we have little control over this disease by medication. As already indicated, quinine, although it may lower temperature, is in large doses even hurtful; no reliance can, according to Veale, be placed in any of the other drugs tried. Saline aperients, aconite, arsenic, turpentine, salicylic acid, carbonate of ammonium, and iodide of potassium have all been used, "but no reliance can be placed in them, either to arrest the fever, or even to diminish the night sweats or the rheumatic pains." The latter, however, can be at least relieved by hypodermic injections of morphine and anodyne liniments. When there is a hemorrhagic tendency, it is kept in check or altogether arrested by the tincture of the perchloride of

iron, or by ergot, or ergotin. Prevention, then, seems in this, as in many other diseases, more hopeful than treatment.—*Br. Med. Jour.*, May 18, 1889.

Ebstein on the Experimental Formation of Renal Calculi.—The author had made, with M. Nicolaier, experiments on dogs and rabbits, and they were able to produce in these animals, by introducing oxamide in their food, renal calculi, the largest of which were localized in the pelvis of the kidney, while the gravel and small grains of sand could be found in any part of the urinary apparatus. The ingested oxamide was white, while the renal concretions were of a grayish-yellow; the largest of them presented on their surface asperities and elevations. The calculi were very hard, and after attrition they observed on the worn surface concentric rings or portions of rings, between which they could distinguish concentric layers having a radiated striation. These concretions are constituted by oxamide and by an organic stratum, giving all the reactions of albuminoid substances. Treating these calculi by means of hot water at 176° to 194° F., the oxamide is dissolved and brings into view the organic stratum, sections of which offer a similar disposition to the worn surfaces, except that the suppression of these radiations reveals the relation which exists between these stellate fibres and the existence of oxamide.—*Med News*, May 18, 1889.

Nancrede (C. B.) on a Hitherto Undescribed Cause for the Failure of the Radical Cure of Hydrocele by Injection.—The patient was an elderly man who had suffered with a moderate-sized, very painful hydrocele for an indeterminate time. In April, 1888, Dr. Simes operated for the radical cure by the injection of carbolic acid. Severe inflammation followed, producing extensive sloughing of the scrotum and presumably of a portion of the vaginal tunic. When seen over a month later, the hydrocele seemed cured. Some time during the next six months the disease recurred, with the old symptoms of constant pain on movement. On coming under my care on April 1st, he showed me a small hydrocele, closely resembling in situation and appearance that first described.

I opened the swelling by a free incision, and considerably to my astonishment, at the junction of the upper part of the epididymis with the body of the testicle, I felt a little calcareous body like a miniature cock's-comb. I removed this with the finger, dissected out a portion of the tunica vaginatis, and, partially suturing the tunica and skin, drained the sac-cavity. Antiseptic methods carried my patient through with no untoward accidents, and at the last reports he was well and free from all his former suffering.

In a similar case, under the care of Dr. Barton, there was found a bony mass, about the size, shape, and hardness of a shrivelled grain of corn.—*Med. News*, May 18, 1889.

Poore (A. G. P.) on Parotitis Communicated from Boy to Dog.—A boy, aged 17, well-grown for a boy of his age, was exposed to mumps on Christmas Eve, at a party given to the young people. Just fourteen days from that date he found that he also had mumps, as many at the gathering on Christmas Eve had. They stayed in his jaws and under his ears just five days, and then they began to jump; they went down to the testicles, and he suffered all the ills that he could in that locality and recovered, with atrophy, however, of those parts.

The patient is now quiet and unassuming, and never boisterous, willing to "live and let live," an attribute he did not possess previous to having the mumps.

The dog belonging to the above-mentioned patient was very fond of him, and stayed in the house under the bed that his master lay on. Previous history good, and he always stayed at home and never fought other dogs. Just fourteen days after his master was taken with the mumps it was noticed that the dog was flopping his ears, and was very much swollen thereabout, and it was thought that he was afflicted with the same malady. This was subsequently proven to be a fact, for just five days after his ears swelled the testicles became enlarged; they still remain much hypertrophied, and the boy wants another dog—one that looks well in society.

This dog is now boisterous, will not cultivate friendly relations with any dog of his sex, and does not stay with the boy, as he did prior to having the mumps, but seeks other company.—*Med. Record*, May 18, 1889.

McDuffie (W. C.) on Disease Communicated from the Human to the Lower Animal.—About four years ago a patient came under my care for treatment for scrofula. The disease at that time

had advanced to such an extent that exfoliation of bone from various parts of the body had taken place, especially from ulcers of the scalp, tibia, etc. The bones of the nose were coming away, accompanied by much of the nasal tissue, producing a hideous appearance and offensive in the extreme. The patient was a married woman, no children, fifty years of age. The past two years she was absolutely unable to help herself, confined to bed all the time, and, of course, a great sufferer. She was very fond of cats, and kept one or two about the bed much of the time during the last year of her life. About fifteen months ago the cat which slept most of the time in bed with her became sick, moped about the room, with swollen eyes and purulent discharge from the nose, sneezing, and soon became a horrid spectacle and finally died, greatly emaciated. While this unfortunate feline was pining away, the patient had adopted another bedfellow of the same species; in about two months this cat sickened and died precisely as the former, with symptoms corresponding to those of its affectionate mistress and its hideous predecessor. Another was then taken in bed to be caressed and to die in about the same length of time, and with the same symptoms. The husband of this poor woman saw by this time the fatal effects upon the gentle mousers, but not willing that his wife should be deprived of any comfort in his reach, procured another famous "rat catcher" from a negro in the immediate neighborhood, and brought it to the now sinking patient, who soon fondled it into perfect acquiescence, and, as the shadows began to lengthen, it, too, manifested the same symptoms of nasal catarrh first, then swollen head, purulent discharge, sore eyes, cough, sneezing, emaciation, etc., until on November 20th last, the long-suffering woman died. That night the cat lay upon the hearth in a sort of comatose state, and lingered until the next day; it expired while the funeral cortége was moving off with the decomposing remains of its late bedfellow. This was the fourth victim in less than thirteen months. In visiting regularly at this house my attention was called to the little animals, as one by one they succumbed to the dreadful malady.—*Med. Record*, March 9, 1889.

The Treatment of Aneurism.—Dr. Aurelio Mutis of Bogotá publishes, in the *Revista Médica* of that city, an account of a case of abdominal aneurism occurring in a patient thirty-seven years of age, which he successfully treated according to the method adopted by Huchard in Paris and by Balfour and Duckworth in this country—viz., complete rest in the recumbent posture, combined with large and long-continued doses of iodide of potassium or sodium. The treatment was commenced on June 1, 1887, the daily quantity of iodide of potassium ordered being sixty grains. A soap-and-water enema was given every morning, and no sitting up permitted. Liquid food also was prohibited as far as possible. Within two months the cough, which had been the most distressing symptom, entirely disappeared; at the end of three months the pain had also vanished, and the tumor, which had formerly existed at a spot a hand's-breadth below the xiphoid cartilage, and which had been as large as an orange and markedly pulsatile, had very perceptibly diminished in size, the pulsations also had decreased in amplitude. The iodide of sodium was now substituted for that of potassium. At the end of six months, the tumor and all the symptoms due to it having entirely disappeared, the patient was allowed to get up and to move cautiously about the room. In a short time he was able to go out, and during all last year he carried on his business as usual, and has remained quite free from all symptoms of the disease up to the present time.—*Lancet*, May 18, 1889.

Barker (F. R.) on an Outbreak of Syphilis Following on Tattooing.—The following are the chief points of interest in this outbreak of syphilis:

It occurred amongst young and healthy soldiers whose ages ranged from eighteen to twenty-two years, with a service of from 3 to 24 months.

Although many of them had lived in London, following occupations which were not in themselves injurious to health, and others were employed in the country, their general appearance was that of fresh-complexioned vigorous lads, who had lived healthy lives.

It is interesting to note the difference in the incubation periods in cases which were tattooed the same day as Cases 2, 3, and 9, which were 29, 47, and 59 days respectively. The incubation periods varied from 13 days, the shortest, to 87, the longest. The length of incubation period appears

to have had no effect in determining the severity of the secondary symptoms, or on the form of ulceration taken, Hunterian or rupial.

It is a fact worthy of notice, that when syphilis is contracted in the ordinary way, *via* penis by sexual intercourse, we rarely have more than one true Hunterian chancre, although at the same time we may have several soft sores or local ulcers, showing that there existed more than one abrasion, through which inoculation might have occurred; yet in one of these cases we had four distinct rupial sores in an area of a circle of an inch and a half in diameter; also that the severity of the secondary phenomena was not proportional to the number of points of inoculation; Case 9, with only one ulcer being the most intractable. It is curious to note that although six cases were tattooed on both arms at the same time by S., in no instance did ulceration occur on more than one arm.

It is the most remarkable feature of these cases that out of the twelve examined, five should have presented a distinct rupial form, and that case 2 should have had secondary rupiæ at the seat of the Hunterian chancres. In no case in which rupial ulcers formed was there a single sore, but their numbers ranged from two to four. In no case did rupiæ form in other parts of the body. I never before heard of rupiæ forming at the seat of the primary sore, and always thought they were regarded as tertiary manifestations; but here we have them as primary or early secondary.

The rupiæ when seen were of the rupia prominens form, resembling limpet shells, and when they fell off left a plain, not an excavated base.

The syphilitic lesions were very uniform in all cases, occurring as enlarged glands, rash, sore throat, condylomata, and mucous tubercles, and usually in this order.

There can be no doubt that the tattooer, S., was the cause of the disease manifesting itself, and that his saliva was the source of the virus, for: (1) No man in any other regiment in the station, tattooed during the same period, contracted the disease, because they were not done by him. (2) Men in the same regiment tattooed, but not by S., did not contract the disease. (3) S. owned he might have put the needles in his mouth; Case 7 stated that S. did put the needles in his mouth. Case 4 stated that the needles before use were dirty as if used before. (5) Case 6 stated that S. rubbed the wound with saliva; S. himself afterwards owned that he might have rubbed the wounds with his saliva; Case 10 stated that S. rubbed his left arm with a cloth; no ulceration followed; but that he rubbed his right with his saliva, and ulceration followed; Case 12 stated that S. was in the habit of spitting on the arm during the process. (6) Case 10 also stated that S. had about twenty patterns on paper, mostly female figures, printed in copying ink, each pattern being able to be used about six times. Six cases were found to be done with the same pattern; he said S. wetted the pattern with saliva before applying it, to obtain an impression. (7) Case 9 stated he saw S. mix the colors, in a small cup he had, with his saliva.

We find that out of the twenty-three cases known to have been tattooed by S., twelve cases contracted the disease, never having had syphilis previously; two cases are stated to have contracted syphilis, but, having deserted, all trace of them is lost; four cases did not contract the disease, having previously had syphilis, showing the immunity one attack affords, although Case 13 stated S. had put the needles in his mouth; five cases did not contract the disease, although none of them had ever had syphilis, and each one denied that S. had put his needles in mouth or used his saliva in any way.—*Br. Med. Jour.*, May 4, 1889.

Bacteriology v. Histology.—The *élan* which the study of bacteriology has taken of late years has proved exceedingly detrimental to histology. Prior to the discoveries which made the new-comer the cynosure of admiring eyes, the attention of biologists was directed to the ultimate structure of the tissues and organs, and the modifications which they underwent, in their search after the cause of disease. No sooner, however, did these wriggling microbes make their appearance beneath the objective of the experimental biologist than pathological micro-anatomy was abandoned, and since then all eyes have been fixed, and all energies concentrated, upon these living, tangible agents of infection. Organs and tissues are still examined, it is true, but only in search of micro-organisms, and the battle-field of science has been transferred to quite another ground, where the infinitely clever wage warfare with the

infinitely little. This departure is somewhat to be regretted, for pathological histology was still an infant science, and was left just when it appeared full of promise. By-and-by, no doubt, when the present enthusiasm about microbes has surfeited itself, observers will return to their earlier love, since, whatever be the *rôle* of the bacterial host, the phenomena of tissue change and degradation cannot be without a very grave importance. Both methods of research must go hand in hand or the necessary data will be wanting whereon to arrive at sound deductions.—*Med. Press*, May 8, 1889.

Rand on Musculo-Spiral Paralysis in a Child.—The child, now three months old, came two months ago with complete pronation of the forearm and wrist-drop. These symptoms were noticed at birth. There was no history of injury, and repeated examinations failed to show any lesion of bone or joint. The child was asphyxiated when born, and the cord was wrapped twice around the arm and once around the neck. The arm was quite deeply creased, and the mark remained for a week or ten days plainly visible to the parents. Prolonged pressure of the cord upon the nerve was the only cause to which he could ascribe the present symptoms. The arm had very much improved under treatment by the interrupted current and massage.—*Brooklyn Med. Jour.*, May, 1889.

Wigglesworth (Arthur) on Extraneous Sources of Puerperal Septicæmia.—The author narrates three cases of confinement without laceration or any injury in which he is satisfied he knew the source of infection which probably gained access to the system by some other route than the genital tract.

In the first case symptoms of sepsis appeared on the fifth day. A thorough examination revealed the fact that the house was full of sewer-gas, which escaped from a defective discharge-pipe in the water-closet. In the second case fever developed on the tenth day, when some garbage pits near by were emptied, filling the house with most offensive smell. In the third case the fever developed in the third week, the day after an offensive cow-stable had been emptied.—*Med. Press*, April 24, 1889.

Sutton (B.) on Leontiasis Ossea in a Man Twenty-Four Years of Age.—The bones of the face were chiefly affected. The symmetrical bony protuberances usually found on each side of the nose in this remarkable disease had been removed at Charing Cross. As the lower jaw had of late increased greatly in size, its right half was removed. The enlarged right upper jaw had encroached upon the orbit-producing proptosis, and on the nasal fossa obstructing respiration. On account of these complications it was successfully removed, the patient recovered rapidly from the operation, but the pressure on the optic nerves still remains, indicating that sphenoid bone is implicated in the disease. Until the operation was performed on the lower jaw, the case was regarded as one of exostosis, but on exposing the jaw its true nature was obvious.—*Med. Press*, May 1, 1889.

Carter (G.) on a Biliary Fistula Through Diaphragm and Lung.—A woman, aged seventy, had had good health, with the exception of occasional "spasms," till two years before, when she had a well-marked attack of biliary colic, followed by jaundice. These attacks continued at intervals of five or six months. In July, 1888, she had a severe attack, in which, by the severity and permanence of the jaundice, with clay-colored motions, it seemed probable that the stone had become impacted. A month after this she had an attack resembling bronchitis, but in which she expectorated about two pints daily of thin dark-green biliary matter. There were large moist sounds at the right base. There was nothing to be felt in the abdomen. Although the discharge occasionally ceased, it recurred, and the patient gradually wasted and died about a month ago. No necropsy could be obtained.—*Br. Med. Jour.*, May 18, 1889.

SURGERY.

Harris (J. D.) on a Case Illustrating the Value of Surgical Treatment of Pulmonary Cavities.—A man of thirty-three suffered from renal abscess, which broke in the left side of the back in December, 1887. Thorough drainage and antiseptic precautions resulted in apparent convalescence in a few months. In March, 1888, signs of pneumonia rather suddenly developed in the left lung. The pneumonia seemed at first to run a favorable course, but in April the symptoms pointed to abscess. In

July an aspirating needle was inserted for three or four inches at the point of greatest pectoriloquy and considerable matter drained away. With the needle as a guide an incision was made into the cavity and a drainage tube inserted. The patient was soon convalescent, and in a few months gained twenty-eight pounds.—*Br. Med. Jour.*, May 4, 1889.

THERAPEUTICS.

O'Donnell (W. T.) on the Use of the Bandage in Mitral Insufficiency.—On January 18, 1889, I was called to see Mr. M., aged fifty-seven. His condition, briefly stated, was as follows: Mitral insufficiency, dilatation of the right side of the heart, general dropsy, hæmoptysis, with cough, jaundice, and anæmia. Urine scanty, and as if holding blood in solution. Action of the heart frequent, irregular, and very feeble. Great dyspnœa. At first a little relief was obtained in the usual way by hydragogues. Then he was directed to take eight ounces of milk every four hours; tincture of iron in fifteen-drop doses, three times per diem; and twelve grains of bisulphate of quinine each morning. The scrotum, distended to its utmost, was then tapped on each side with a large-sized aspirator needle, which was permitted to remain for a time, so that when withdrawn, the opening thus made should not be plugged by oozing blood. In this way, by four successive tappings, about seventeen quarts of fluid were withdrawn. As the dropsy disappeared from the upper portion of the body, he had severe pleuritic pains, which were relieved by morphine. Finally, the legs being still distended, he was placed upon his back, with shoulders and legs elevated, and kept thus twenty-four hours. A bandage was then applied from feet to body as tightly as possible, yet each ascending turn compressed the limb slightly less than the one preceding it. He was again placed upright, when the scrotum rapidly filled and was tapped for the last time. The scrotum was then compressed by means of adhesive straps, and the bandages were carried to the nipples. His arms were also bandaged.

So soon as the dressing was *in situ* the heart became vastly more regular in its action, the urine more copious and clear, cough and blood-spitting ceased, and he was encouraged to walk, leaning upon the arm of an attendant. From this time, January 30th, the improvement was rapid and continuous, and by the end of February he was able to attend to his business, and has superintended the seeding of a large wheat farm.

The bandages, excepting those for the arms, are still *in situ*. An attempt to lay them aside was at once followed by increased heart trouble and incipient dropsy. *N. Y. Med. Jour.*, June 1, 1889.

North (N. L.) on Anomalous Action of Nux Vomica and Strychnine.—The author has seen these drugs produce, particularly in the aged, a very irregular action of an ordinarily correct and fairly acting heart.

To a woman of sixty suffering from indigestion, flatulence, cardialgia, etc., the writer gave a mixture containing pepsin, bismuth, syrup of ginger, mint-water, etc., with five drops of tincture of nux vomica to the dose. One dose after eating caused distress, disturbed and rapid respiration, and suffusion of the face. The heart was in great commotion, irregular, indistinct, intermittent, and occasionally very rapid. Brandy and digitalis gave relief. On two subsequent occasions the same symptoms followed the same dose of nux vomica.

A man of sixty-five was taking a laxative pill containing $\frac{1}{60}$ gr. of strychnia with a small amount of aloin and belladonna during convalescence from typhoid fever. He complained of nausea and faintness on sitting up, and had a weak, irregular, intermittent pulse. His face was turgid, suffused, and extremely anxious. Stopping the medicine relieved the symptoms.—*Med. Rec.*, May 25, 1889.

Farlow (J. W.) on the Use of Belladonna and Cannabis Indica by the Rectum in Gynæcological Practice.—It has seemed to the author that, while the direct application of medicinal substances to the uterus and vagina has received the attention it merits, the absorbing power of the rectum and its intimate relation to the different pelvic organs have been somewhat neglected. Whoever is in the habit of examining many patients by the rectum is aware how the cervix, the posterior and lateral portions of the uterus, the broad ligaments, tubes, ovaries, Douglas' fossa, the utero-sacral ligaments, in fact, nearly the whole pelvic contents, are within easy reach.

The author has used belladonna and can-

nabis indica for years. Belladonna has a sedative action on the uterus and pelvic contents, and relaxes the bowels. Its value in irritable conditions of the bladder and urethra is well known. This combination of qualities is called for in a very large number of women. Cannabis has somewhat similar qualities, and is productive of much good in cases of sensitive, painful ovaries. In the nervous headaches of women with pelvic troubles it has no equal. In the vague neuroses of the menopause, both drugs are extremely useful.

As regards dosage and manner of administration, I do not think there is any thing to be gained by pushing the drugs to their physiological action. I have generally ordered a quarter grain each of extract of belladonna and extract of cannabis indica in a rectal suppository, to be used at night, and sometimes it is well to use one also in the morning after the bowels have moved. There are some patients who can tolerate only one eighth grain of extract of belladonna, even by the rectum. To such, smaller amounts should be given.—*Boston Med. and Surg. Jour.*, May 23, 1889.

McCall (R. B.) on Salol in the Vomiting of Indigestion and of Pregnancy.—The author says that whenever there is indigestion characterized by acid and gaseous eructations or putrefactive changes, or gastric or intestinal catarrh from fermentation, salol is of value. In the indigestion of childhood, from over-feeding or indulgence in indigestible food, where there is a heavily loaded tongue and fetid breath, the drug may be used with good effect.—*Med. News*, May 25, 1889.

Fowler (W.) on Poisoning by Chromic Acid.—An emotional woman of 45 had enlargement of the lingual tonsils, to which the attending physician applied a saturated solution of chromic acid on a cotton probe. Against explicit directions, the patient swallowed a drop or two of the acid. Slight burning of the throat was felt, and in half an hour violent pain in the epigastrium with severe and agonizing vomiting of a green, ropy fluid came on. Alarming collapse set in with contracted pupils and slight deafness. Stimulants and hot bottles brought the patient around in three hours. An hour after ingestion the acid caused purging, and the subsidence of alarming symptons was accompanied by copious urination.—*Br. Med. Jour.*, May 18, 1889.

MISCELLANY.

DEPARTMENT OF THE INTERIOR,
CENSUS OFFICE,
Washington, D. C., May 1, 1889.

To the Medical Profession:

The various medical associations and the medical profession will be glad to learn that Dr. John S. Billings, Surgeon U. S. Army has consented to take charge of the Report on the Mortality and Vital Statistics of the United States as returned by the Eleventh Census.

As the United States has no system of vital statistics, such as is relied upon by other civilized nations for the purpose of ascertaining the actual movement of population, our census affords the only opportunity of obtaining near an approximate estimate of the birth and death rates of much the larger part of the country, which is entirely unprovided with any satisfactory system of State and municipal registration.

In view of this, the Census Office, during the month of May this year, will issue to the medical profession throughout the country "Physician's Registers" for the purpose of obtaining more accurate returns of deaths than it is possible for the enumerators to make. It is earnestly hoped that physicians in every part of the country will co-operate with the census office in this important work. The record should be kept from June 1, 1889, to May 31, 1890. Nearly 26,000 of these registration books were filled up and returned to the office in 1880, and nearly all of them used for statistical purposes. It is hoped that double this number will be obtained for the Eleventh Census.

Physicians not receiving Registers can obtain them by sending their names and addresses to the Census Office, and, with the Register, an official envelope, which requires no stamp, will be provided for their return to Washington.

If all medical and surgical practitioners throughout the country will lend their aid, the mortality and vital statistics of the Eleventh Census will be more comprehensive and complete than they have ever been. Every physician should take a personal pride in having this report as full and accurate as it is possible to make it.

It is hereby promised that all information obtained through this source shall be held strictly confidential.

ROBERT G. PORTER,
Superintendent of Census.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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MEDICINE.

A Case of Death Following the Suspension Treatment of Locomotor Ataxy.—In the current number of *Le Practicien*, a case of death following the suspension treatment of locomotor ataxy is recorded by Dr. Gorecki, of which the notes are as follows: A man, aged forty, who had been ataxic for five years, happened to read in a lay journal an account of the treatment of locomotor ataxy by suspension. The good report which was appended of the satisfactory results which had followed this method prompted him at once to invest in the apparatus and proceed to experiment upon himself. The disease was so far advanced that he was almost paraplegic, and feeling that there was a great latitude for improvement, he was naturally anxious to leave no stone unturned which might be calculated to ameliorate his desperate condition. Acting, then, upon this conclusion, with the necessary apparatus at hand, he was suspended by his domestic for from two to three minutes daily. The first seven "séances" were most satisfactory in their results. An obvious improvement ensued, so much so that he regained to some extent the power of walking, and he was beginning to congratulate himself on his continued progress. At the termination, however of the eighth "séance" he found to his amazement that he had suddenly become deaf and speechless. The vision, on the other hand, was unaffected, and his intelligence and power of voluntary movement were at the time unchanged. A practitioner was at once sent for, who administered injections of ether, and otherwise prescribed, but nothing was of any avail. The symptoms rapidly developed. Deglutition soon became impossible; absolute blindness supervened, and in the evening of the day upon which the last suspension had been practised, the paralysis invaded the arms and thoracic muscles, and death occurred from asphyxia. It is of course not far to seek a moral of this untoward incident. If it shows nothing else it proves incontestably the inexpediency of making lay journals the medium of imparting professional statements to the public. The enterprise of some of our foreign contemporaries in this respect often exceeds their discretion. It can scarcely be said that even with the best authorities on the subject, the details in regard to the suspension treatment have been unequivocally worked out, and yet we have here a man who reads probably a florid description in a lay journal of how locomotor ataxy can be improved by suspension, actually purchasing the apparatus for himself and undertaking his own treatment, oblivious of its difficulties, its dangers, and the necessary precautions to be observed in its practice. If we speculate for a moment, however, in regard to the probable immediate cause of death, the case presents some points of interest which cannot be ignored. The symptoms traced from their commencement at the last "séance" seem somewhat to resemble those which would follow compression—as from blood—of certain parts of the nervous system. But however this may be, science

would have gained something by a full description of the pathological changes observed in the brain and spinal cord of this patient, but no post-mortem inquiry seems to have been made.—*Med. Press*, May 29, 1889.

Copeman (S. M.) on an Unique Case of Biliary Fistula, with Some Observations on the Bile Obtained from It.—The outcome of these experiments may be summarized as follows: 1. The normal amount of bile secreted by the liver is about 48 oz., or 2½ pints, per diem in a man of 12 st. 2. The rate of flow varies in accordance with the time of ingestion of food, there being usually a rise between one and two hours after a meal. The secretion, moreover, is not a continuous one, the bile being extruded into the gall-bladder by repeated peristaltic contractions of the bile-ducts. 3. The color of the bile in man is probably always of an olive-green color, biliverdin, and not bilirubin, being the pigment which is present in greater quantity. 4. The amount of solids present is normally about 10 per cent., this percentage being kept up by a continuous re-absorption of the bile salts from the intestine following on their secretion; the specific gravity of the bile falling when it is drained away as fast as formed, as occurs in a fistula. The amount may also be increased after the bile is first formed by absorption through the walls of the gall-bladder. 5. Bile is necessary to the assimilation of fats, but not absolutely so, although doubtless of use, for that of proteids. Its purgative action is more than doubtful. 6. The bile has no true antiseptic action, although it is able to a small extent to control putrefactive changes. 7. Stercobilin probably is formed by reduction of the bile pigments in the intestine; but urobilin appears to be formed in the liver, together with the bile pigments by a slight change of metabolism. —*Lancet*, June 1, 1889.

Nicholson (F.) on Pseudo-Hypertrophic Muscular Paralysis Occurring in Four Brothers.—The above condition occurs, as a rule, in family groups far more frequently than as isolated cases.

The parents are both fifty-three years of age, and have been married twenty-seven years. They both enjoy very good health, and there is no history of pseudo-hypertrophic paralysis in either family, nor is there any taint of phthisis, cancer, syphilis, or insanity that I can discover. The husband is a coachman, and looks strong and well, and his wife is a typical example of a healthy-looking countrywoman. They were not related, and have had eleven children. 1. A boy who died at the age of seventeen of pseudo-hypertrophic muscular paralysis. The symptoms were first noticed at the age of two, when the child was noticed to walk clumsily and badly; soon afterwards the muscles of the calves and thighs assumed very large proportions, and he walked with the back much arched and the shoulders and head thrown back, and he raised his feet from the ground with difficulty. At the age of eight he became quite unable to walk at all, and died suddenly; the exact cause I cannot trace. 2. A boy, now aged twenty-five, and in excellent health. 3. A girl, aged twenty-three, and in very good health. 4. A boy, who died at the age of fifteen of pseudo-hypertrophic muscular paralysis. Was very late in walking, which he did very awkwardly. The calves and thighs grew extremely large, whilst muscular power got less and less, and at the age of three he was unable to walk alone. After living for some years in a helpless condition, he succumbed to lung mischief. 5. A boy, now aged eighteen, and in very good health. 6. A girl, aged seventeen; quite strong and well. 7 and 8. Twins, both boys, and born sixteen years ago. Both suffered from pseudo-hypertrophic muscular paralysis, and of these I shall speak more in detail directly. 9. A girl, now aged fourteen, and in good health. 10. A girl, who died of phthisis at the age of twelve. 11. A boy, who died at the age of fourteen months, after an illness of five weeks, said to be due to teething.

I first saw the seventh and eighth children, both of whom suffered from this disease, in December, 1886. They were twins, and small for their age, which was then fourteen. The larger of these two boys, who is still living, is said to have been a fine healthy child at birth, and nothing was noticed amiss till the boy was two years old. It was then observed that he was very unsteady on his legs, walking clumsily and awkwardly, going upstairs with difficulty, and falling very readily. During the next five or six years it was noticed that the calves and thighs were much larger than natural, whilst the gait was swaying and peculiar, the back being

much arched and the shoulders thrown back. Latterly these muscles had wasted a good deal, and towards the end of 1886 the boy was unable to walk or stand alone. In December, 1886, the calves were still very firm and hard, and large in proportion to the general development, each measuring 10¼ in. in diameter; the gluteal muscles were big, but softish; so also were the hamstrings; but the quadriceps extensor was much wasted on both sides. The knees and left ankle were freely movable, but the right foot for a good many years had been in a position of equino-varus. The muscles of the arms were all somewhat wasted and soft, except the left infraspinatus, which was markedly large and firm. Though quite unable to stand alone, he could do so when held or leaning against a chair or table, and then the lumbar curve appeared much exaggerated and the shoulders were thrown back. In general health he seemed very well. I have seen this boy again recently, and I now find the left infraspinatus, which was very large, considerably wasted, and there is much wasting of the muscles of both arms. The right calf is slightly less than it was, and now measures 10 in., whilst the left is larger and firmer than before, and measures 11½ in. The glutei and hamstring muscles are now much wasted, and both knees are rigidly fixed at a right angle; the deformity of the right foot is as before, whilst the left foot still continues natural. The boy eats and sleeps well, can dress himself, crawl about, and get downstairs alone, but has to be carried upstairs.

The smaller of the two boys, in December, 1886, though his age was fourteen, looked only about eight. He was then confined to bed with a high temperature, cough, and physical signs in the right lung, pointing to a rapid phthisis. He was a healthy and strong child at birth, but at the age of two he had trouble in walking. For several years the calves and thighs kept increasing in size, whilst his walking powers got worse and worse: but during the last three or four years the muscles had all wasted a good deal. Fifteen months previously he could not walk alone, and since then he had been gradually getting worse and more helpless. In December, 1886, he had for about six weeks been suffering from cough and feverishness, and was much emaciated and very feeble. He died early in 1887.—*Lancet*, June 1, 1889.

Zenner (P.) on a Case of Diabetes Insipidus, with Favorable Termination. — A boy of twelve years, about a year before I first saw him, had an attack of intercostal neuralgia. A few months subsequently, before the neuralgia had disappeared, he was seized with acute articular rheumatism, in the course of which a cardiac murmur was heard, and somewhat later chorea developed. Seven months prior to my seeing him his physician first observed that he had polyuria.

The boy at this time presented the ordinary appearance of fair health. He was fairly nourished, though the muscles were rather flabby and he had lost somewhat in flesh. A great deal of restlessness was manifest; he seemed never to sit quietly, and there were some irregular movements, not distinctly choreic, in the left arm. There was still a trace of articular rheumatism, and some tenderness and slight swelling about the left knee. There were also tender spots in the left third, fourth, and fifth intercostal spaces. He suffered with pain in the same intercostal spaces, as well as in the neighborhood of the third and fourth dorsal vertebræ—a pain not constant, and yet more fixed in character than that of ordinary neuralgia. There was no paralysis or paresis; the pupils and patellar tendon reflexes were normal, and nothing abnormal was detected about the heart. His appetite was very capricious, and he did not suffer with thirst.

He passed large quantities of urine, which had the appearance of distilled water; it contained neither albumen nor sugar, and had a specific gravity of less than 1,001. He was able to hold his urine only a few minutes, never longer than five, and then it escaped from him, however much he attempted to hold it. For this reason he was compelled to wear a rubber bag constantly.

The quantity of urine was collected and measured for only part of the day, in each instance for seven hours from 7 A.M. to 2 P.M. At the first measurement, September 2d, eight pints were voided in this time, making, providing the flow were equal throughout the day, about twenty-seven and one half pints in twenty-four hours.

The first week he was put upon electrical treatment, without the use of medicine; then he was ordered seven and one half grains of antipyrin three times a day, and about a month subsequently one half tea-

spoonful of powdered valerian root three times a day. The electricity, antipyrin, and valerian were continued until full recovery.

The electrical treatment consisted of the application of the galvanic current to the cervical sympathetic, and to the spine, especially over the region of pain. The current used was of moderate intensity, the applications being made daily the first month, and subsequently two or three times a week, each of about ten minutes' duration. In the beginning applications of either faradic or static electricity were also made to the region of the bladder to strengthen its sphincter, but, as the patient objected to these applications and they did not seem to effect any thing, they were soon discontinued.

The improvement in the polyuria and condition of the bladder was exceedingly slow, while the other symptoms were ameliorated more rapidly, the appetite soon returning and the pains entirely subsiding within a month or two.

On March 3d he passed only twenty ounces in twenty-four hours, the quantity remaining about the same subsequent to this time.

The specific gravity was for some time less than 1,001. On October 14th it was 1,003; February 17th, 1,007; March 3d, 1,023. With the diminution of the quantity of urine there was a proportional improvement in the power of the bladder to retain urine. At first he could not hold water longer than five minutes. Gradually the time was extended to six, seven, eight minutes, so that when he had been under treatment about three months he could hold it twelve minutes. February 17th he could retain urine forty minutes; February 26th, one hour; while on March 3d he retained the urine all night. From the time of the latter date his condition appeared to be normal, and all treatment was discontinued.

It is noteworthy that while the improvement was so slow for months that it was scarcely perceptible from week to week, toward the last it was very rapid.

It is very singular that, notwithstanding the enormous quantities of urine passed, he did not suffer from thirst, and drank very little. He usually drank nothing between meals, and then took no more than one or two glasses of milk and a cup of coffee, or the like. So great seems to be the discrepancy that one might be inclined to believe that there was deception somewhere, but his family corroborated the statement of the apparent absence of thirst, and the specific gravity of the urine below 1,001 (I often had him pass it in my own presence) indicated that a large quantity of urine must have been voided.—*Cincinnati Lancet-Clinic*, June 8, 1889.

Russell (W.) on the Influence of Hereditary Predisposition in Epilepsy.—The writer was called to see a child of ten in "fits," and the following hereditary history was obtained. The parents of the child were healthy and had had six children, three boys and three girls. All the boys at one time or another had "fits." The mother had nine brothers and three sisters; of the brothers two had "fits." The father had five sisters and four brothers, and three of the latter had "fits" now and again.—*Glasgow Med. Jour.*, June, 1889.

THERAPEUTICS.

Thompson (W. G.) on the Therapeutic Value of Oxygen.—In the author's experiments it was found that all the animals could exist comfortably in the oxygen until a pressure exceeding three atmospheres was employed. The higher orders of animals were affected before the lower ones. As a rule, a decided fall of temperature, often amounting to from 4° to 6°, was observed; and only in cold-blooded animals was there any rise in temperature. This marked decrease in temperature he did not believe was to be attributed at all to the effect of the oxygen, but to the profound disturbances in the system caused by the high pressure employed. If, as was claimed by the older writers, a greatly increased tissue-metamorphosis was caused by oxygen, this would unquestionably be accompanied by an increase, and not a diminution, of the body temperature. In animals subjected to oxygen in a pneumatic chamber under increased pressure, he found that the temperature was reduced several degrees, and rabbits in which septicæmia had been artificially produced, had the temperature reduced to normal.

In such of the animals as died as a result of subjection to high pressure of oxygen, or were killed after removal from such

pressure in the pneumatic drum, Dr. Thompson found pulmonary engorgement and dilatation of the right heart. The convulsions which usually resulted when the pressure was carried to a high point, were, as a rule, quickly controlled by blowing off five pounds of pressure.

In considering the therapeutic value of oxygen it was to be borne in mind that it was a physical impossibility to take oxygen into the blood. This agent had been employed, first, as a curative in certain diseases of the blood and circulation, and second, as a palliative in dyspnœa due to various causes. Of late, its use has increased to such an extent that two or three hundred thousand gallons of it were now consumed annually in New York city alone. Among the affections, in addition to dyspnœa from whatever cause, in which it was claimed that it had proved of benefit, were anæmia, chlorosis, croup, chronic gastric catarrh, migraine, cholera, and opium narcosis.

In anæmia, chlorosis, etc., Dr. Thompson said he could see but little advantage over good fresh air in giving diluted inhalations of oxygen two or three times a day, as was the usual practice in such affections. It did not seem rational to him to expect that sufficient oxygen could enter the system, under these circumstances, to produce any thing but a temporary effect. In cases of blood-poisoning, again, he had failed to see any relief afforded by oxygen. In certain subjective cases of dyspnœa it might relieve, but in a case of poisoning by illuminating gas, which he had seen at the Presbyterian Hospital, it was kept up for nearly three days without any effect either on the rate of breathing or on the cyanosis present. In cardiac diseases his experience with oxygen had not been encouraging, and he referred particularly to a case of malignant endocarditis, in which it proved of no avail in relieving the dyspnœa. In certain cases of asthma and of uræmic dyspnœa, however, it gave decided relief, and in such he believed it was an invaluable therapeutic agent; though not, of course, curative.—*Med. News*, May 25, 1889.

Mansfelde (A. G.) on Inhalations of Chloroform in Phthisis.—D. H——, from Massachusetts, came to me, January 7, 1889, and was treated until February 16th by inhalations of chloroform, the vapors of which were saturated with turpentine and balsam of Peru, all of this being forced into the lungs by compressed oxygen gas. His wife writes to me: "Mr. H—— has been out every day since our return, either walking or riding, some days both; last Thursday worked three hours at carpentry; seemed tired, but not exhausted. Yesterday helped me in papering a room an hour or more, besides walking down town twice, about a quarter of a mile, and now contemplates painting a room."

At this writing the patient is steadily improving, and if it is noted that he could scarcely be out of bed when he came to me, the conclusion is justifiable that he has been reclaimed by the means employed. —*Med. Record*, May 25, 1889.

McKim (W. D.) on a Death from Ether.—A man of forty-six had suffered for more than a year from tubercular disease of the tarsus. He had aortic and mitral systolic murmurs with feeble heart-sounds. The urine was slightly albuminous. After the administration of half an ounce of whiskey, the etherization was commenced. In a few minutes the respiration faltered and the patient became deeply cyanosed, but this somewhat alarming condition quickly passed away. About five minutes later, the assistant having the pulse under observation suddenly announced that it had ceased. Immediately hypodermatic injections of brandy, ether, and sulphate of atropine were given; amyl nitrite was applied to the nostrils, artificial respiration was practised, and the head and shoulders were depressed by the elevation of the foot of the table; but all was in vain; the patient was dead.

The ether used was æther fortior manufactured by Squibb.

Autopsy.—No rigor mortis. Body well nourished. *Lungs:* Very small, otherwise normal. Left pleura, a few adhesions, no fluid. Right pleura, no fluid, many adhesions. Lungs slightly congested. *Heart:* Hypertrophied; pericardium everywhere adherent; coronary arteries of small caliber; slight atheroma of the aorta; mitral valve stenotic. *Spleen:* Enlarged. *Kidneys:* Left atrophied, capsule adherent, markings indistinct, sclerosis above the pyramids; pelves filled with fat. Right kidney in about same condition; both surrounded by a thick layer of fat. *Stomach:* Normal.

The most striking revelation of the autopsy was the complete adhesion of the two surfaces of the pericardium. The death seemed due, then, to syncope, the

heart being so fettered that it could not respond to the unusual strain thrown upon it. When beginning the inhalation of ether, the patient seemed very nervous, there was rather more struggling than usual, and a struggle closely preceded the disappearance of the pulse. The heart was in a condition to suffer permanent arrest of its function upon any slight increase of labor, and any occasion for unusual mental or physical excitement would, I think, have been as fatal as the ether. Had much more than ordinary care been exercised to quiet the patient's nervousness, and to restrain his jactitation by moral suasion and the gentle and gradual administration of the ether, I can readily believe that this feeble heart might have successfully emerged from its ordeal.—*N. Y. Med. Jour.*, May 18, 1889.

Peterson (F.) on Electric Cataphoresis as a Therapeutic Measure.—According to the author, the cataphoric action of the constant current is beyond doubt or question, but the use of the Adamkiewicz electrode or of chloroform for cataphoresis is altogether inadmissible.

His own experiments have been chiefly with cocaine and aconitine. With the former, or with the two combined, a deep anæsthesia may be produced in conjunction with the anode, sufficient for the relief of pains in superficial nerves, or for small operations—such as the painless removal of cutaneous growths, or the electrolysis of hair roots.

The anæsthesia may be made rapid by the use of strong currents—an advantage in neuralgias,—or slowly produced with a current imperceptible to the patient.

Wherever and whenever the anode is employed for the relief of pain, its efficacy will be greatly increased by moistening it with a ten- to twenty-per-cent. solution of cocaine.

Rubbing the skin with a little alcohol or chloroform, to remove the oil globules previous to the application, will hasten the effect.

The method is of particular benefit in neuralgia of the trigeminus and its branches. If volatile solutions are used, evaporation may be prevented by the employment of a tight-fitting, bell-shaped, soft-rubber cap, adjusted over the end of the electrode. In none of the experiments with cocaine or aconitine did any excoriation or other injury to the skin follow, but occasionally there was slight scaling of the epidermis. There were, of course, no constitutional effects.

The author suggests the use of electric cataphoresis for other purposes than that of producing topical anæsthesia. Wherever, for instance, iodine is used as a local application over swellings or tumors, the galvanic anode will greatly add to the efficacy of the medicament.—*N. Y. Med. Jour.*, April 27, 1889.

Browne (L.) on the Cocaine Habit in Diseases of the Throat and Nose.—That the drug loses even its analgesic action after long use, is exemplified by the diminished relief it affords after a time to dysphagia occasioned by tuberculosis or other ulceration—the most justifiable indication for its continuous employment. Similarly, while in the first instance promoting salivary and mucous secretion, it is later found that patients who long indulge in cocaine applications suffer from abnormal dryness of the throat. Further, its good effect in temporarily relieving capillary engorgement of the turbinated bones, etc., results, if its use is unduly prolonged, in either an anæmia with atrophy, or a no less inconvenient increase in the intensity and chronicity of the hyperæmia. Lastly, I have seen two cases, in which I believe anosmia to have been induced, or at least aggravated, from this habit. Needless to add that the amount of cocaine absorbed into the system has an injurious general effect on the health in the shape of a debilitated vasomotor system.—*Br. Med. Jour.*, June 1, 1889.

Batten (R. D.) and Bokenham (T. J.) on the Physiological Action of Antipyrin.—From experiments and observations on the action of the drug, the authors conclude that its main, if not its sole, action is due, directly or indirectly, to its influence on the nervous system. It appears to act on all parts of it—mainly on the spinal cord, but also on the brain and motor nerves.

If it is fair to compare the symptoms produced by a drug with those the result of disease, the symptoms in question bear a very strong resemblance to those of lateral sclerosis, and they therefore think that the action of the drug may be localized in the lateral columns of the cord. For instance they found in guinea-pigs and a cat, spastic rigidity of the hind limbs, and, in all animals experimented upon, rigidity

formed a marked symptom. Further, in the first-mentioned animals this symptom appeared to come on with any attempt to use the limbs, just as is the case with a patient with lateral sclerosis.

The excess of myotatic irritability is also very marked, the slightest tap being sufficient to evoke violent muscular contractions, and in extreme cases to cause clonic spasms of the whole body. In one experiment, phenomena exactly similar to those of ankle clonus were obtained.

In all cases the contrast between the effect of painful stimuli and stimuli such as the slightest taps, or even the vibrations produced by walking about the room, was most marked, the former producing less effect than in a normal animal, while the latter caused the violent spasmodic movements already mentioned.

In the present instance, the effects of the drug (antipyrin) are so transient, seldom extending over more than a few hours, and the recovery is so complete, that pathological results demonstrable by the microscope could hardly be expected. It is rendered more difficult from the fact that doses sufficient to cause death produce other symptoms not referable to the lateral columns alone.

As regards the action of antipyrin on the brain of mammals, but little can be said at present. From the rapid rhythmic movements noticed in many cases, and from the circus-movements sometimes observed, it may be concluded that either the motor centres themselves are involved, or that their inhibitory power is abolished.

In cases of poisoning by antipyrin, it is interesting to observe that here also the symptoms are mainly nervous. In three cases observed by one of the authors, the symptoms were great restlessness, anxiety, and giddiness, the patients complaining also of "pins and needles" in the legs and feet. In another case, a girl taking 3 grammes daily for chorea became on the third morning drowsy, giddy, and finally delirious, with labored, slow breathing, these symptoms lasting for about five hours. Dr. Jennings also records a case in which a maniacal condition followed the administration of large doses of the drug. It is striking how closely many of these symptoms resemble those which we have been able to produce in animals.—*Br. Med. Jour.*, June 1, 1889.

Beyer (H. G.). Can Pneumonia be Cut Short by Antipyrin?—The author thinks pneumonia is cut short by antipyrin. He gives morphine hypodermically and later twenty to thirty grains of antipyrin. He claims that antipyrin is a cardiac tonic which lacks some of the disadvantageous features common to other cardiac tonics, *i.e.*, the contraction of peripheral vessels. He thinks the drug strengthens the heart and dilates the pulmonary vessels, both of which acts, he thinks, markedly relieve venous congestion and equalize the general circulation.—*Med. News*, June 15, 1889.

Beale (G. B.) on Liquor Ammoniæ Acetatis *v.* Antipyrin in Pneumonia.—Last year I had a case of pneumonia, temperature 104°, and the right lung giving all the usual physical signs. I saw the man at 5 P.M. on the first day, and ordered him liq. ammon. acet., 3 vi.; tinct. camph. co., ℥40, every four hours. On the second day at noon the temperature was 100°, and on the morning of the third day normal; and, except that there was still a certain amount of rusty expectoration, the man was well, and wanted my consent to his going to work. I do not think antipyrin could have done much more in forty-two hours, and do not feel very sure that the liq. ammon. acet. deserved the credit; but, rather, that very probably the same result would have been obtained without either, but with the usual treatment by poultices, etc.—*Lancet*, May 18, 1889.

Pilcher (L. S.) on the Antitubercular Power of Iodoform.—A girl of thirteen had an infiltrated and ulcerated patch on each leg. One was treated with iodoform and one with bismuth. The former promptly healed, while the latter started off well, but later the epithelial elements broke down, and a number of small ulcers formed, at the base of each of which a particle of bismuth was found.

No bacilli were found in either location at the expiration of treatment.—*Med. News*, June 1, 1889.

Park (R.) on the Action of Quinine in Medicinal Doses on the Pregnant Uterus.—A woman, æt. twenty-seven years, three years married, never pregnant, consulted the writer in August, 1886. On examination, he found her suffering from retroversion of the uterus, with tender fundus. This was replaced without difficulty, and a Hodge pessary introduced, the relief from which was entire and immediate. She soon thereafter became pregnant. In August, 1887, when about five

and a half months pregnant, she was threatened with a miscarriage—considerable discharge, with rhythmic pains, which, however, subsided on the administration of opium, with small doses of liq. ergot. ammon.; and, on 31st December following, was delivered of a healthy and vigorous female child. On inquiring as to the cause of the hemorrhage, Dr. Park could elicit absolutely nothing, except that, three days previously, she had taken a dose of quinine to relieve a neuralgia. He considered that she must have taken from 10 to 15 grains, from the effects produced on the head. The patient herself stated that soon after the singing in her ears stopped she began to feel uneasy about the lower part of the abdomen. — *Glasgow Med. Jour.*, June, 1889.

Hund (J.) on Salicylate of Soda in Drachm Doses.—The author reported, a year ago, three cases of rheumatism treated in this way, and now reports four additional cases.

CASE 1.—Male of twenty-nine, slight rheumatic pains all over, worst in left shoulder and arm. Salicylate of soda 3 i every three hours until three doses were taken. Next day free from pain, but no appetite. Fourth day perfectly well.

CASE 2.—Male of thirty-nine. Treatment commenced Jan. 4th. Discharged well Jan. 11th.

CASE 3.—An adult male, admitted to hospital Jan. 4th. This was a very bad case, right knee being extremely swollen and sensitive. Patient suffering at the same time from the effect of the too free use of the good things of life. Treatment tentative internally and liniment externally. Chloral was administered at night to secure sleep.

Jan. 5th.—Patient no better, same treatment continued, with hot applications to knee.

Jan. 6th.—Doing rather poorly.

Jan. 7th.—No change apparent.

Jan. 12th.—Patient very miserable; sleep impossible, and consequently morphia was substituted for chloral, and the sod. salicylate in the proposed manner was administered, the first dose at 2 P.M. and the next at 5 P.M. No appetite for supper. At 7 P.M the man was cold all over his body and in a profuse perspiration. His pulse was rather weak and stimulants were called for. Whiskey and digitalis brought up the sluggish circulation. He was well covered and the third dose of sod. salicylate administered, which gave him relief.

Jan. 12th.—No more pain, but extremely weak. No appetite as yet.

Jan. 13th.—Much better, good appetite. He sat up and can step on his leg without experiencing any pain.

Jan. 14th.—Left for home. Still slight swelling, but no more pain. A little weak and stiff.

CASE 4.—An adult male, also with rheumatism manifesting itself in the right knee. This was an out-door patient and came for treatment. Jan. 19th gave him two doses at the hospital and sent him home at his request to take the third. He came next day free from rheumatism. On the 24th he returned and complained of recurrent pains in his knee. Gave him two doses of a drachm each, and ordered him to stay in bed two days, and not go out of the house for a few days afterward. He had no more trouble.—*Western Med. Reporter*, May, 1889.

SURGERY.

Sherman (H. M.) on Reproduction of the Entire Ungual Phalanx of the Thumb by a Single Bone Graft.—A boy of thirteen had the entire ungual phalanx of the right thumb carried away by a punch. The nail was torn away and there was much contusion of the parts.

A small wedge containing cartilage and bone with its line of ossification was cut from the scapula of a healthy Newfoundland puppy and inserted in the place of the lost phalanx. Recovery ensued with complete extension, about 45° flexion and some lateral mobility of the terminal phalanx, and altogether a very useful member.—*Pacif. Med. Jour.*, June, 1889.

Robson on Successful Tendon-Grafting.—The patient's forearm and hand suffered severe injury involving principally the ulnar border. The dorsum of the hand was entirely divested of muscular and tendinous structures, and the palm was extensively lacerated. Wishing to preserve the arm if possible, he took a piece of hanging tendon from the front of the hand, four inches and a half in length, and stitched it to the extensor muscles and to remaining fragment of the extensor tendon. The wound was kept aseptic and no sloughing took place. The man now had good

movement, and was able to return to his work as a weaver. The hand could be pronated and supinated, and he could move the thumb and index finger. He had taken a good length of tendon, and had secured it by a single suture at each end. He believed it was the first successful case of tendon-grafting, and the good result he attributed to the use of antiseptics, to taking a sufficient length of tendon, to using a single suture only at each end, to the immediate transference of the tendon, and to the non-use of drainage-tubes.—*Lancet*, June 1, 1889.

Senn (N.) on Laparotomy for Perforating Typhoid Ulcer.—The patient was a man of twenty-two, in the third or fourth week of typhoid fever. On operation the perforation was found and closed by sutures, but the patient died in seven hours from the effects of a septic peritonitis which antedated the operation.—*Med. News.*, June 8, 1889.

McGraw (T. A.) on Gunshot Wounds of the Abdomen.—In discussing the subject the following propositions were considered — many of them based upon experiments upon dogs and sheep.

1. The gravity of an injury of this kind depends partly upon the size of the missile.

2. Gunshots which enter the abdominal cavity pass in a nearly absolutely straight line from the orifice of entrance, through the peritoneum to that of exit or to their final stopping-place in the viscera. All apparent deviation of bullets fired into the abdomen from a direct path are due to changes in position subsequent to the shooting.

3. An incision made directly in the course of the ball will give the shortest route to the injured viscera.

4. The contents of the bowels may be made to discharge through an open gunshot-wound by manipulation and pressure.

5. An empty condition of the alimentary canal is most favorable to healing. To secure this it may be proper, in some cases of injury of the bowel, immediately after a hearty meal to evacuate the contents of the stomach by means of a siphon.

6. Agglutination and limitation of the morbid processes consequent upon gunshot wounds may take place as early as the sixth day.

7. Senn's method of hydrogen gas insufflation, however admirable in recent cases, should be used with great caution in cases four hours old, and especially in those made by small bullets.

8. The dangers of the operations for penetrating gunshot-wounds of the abdomen are directly in proportion to the length of the operation and to the amount of the evisceration. The duration of the operation may be lessened: "1st, by making the incision over the line taken by the ball, or, if it has passed from before backward, over the point of entrance; 2d, by limiting the examination of the viscera strictly to such of them as may have been in the course of the ball; 3d, by suturing wounds of the intestine, whenever it is possible, instead of excising them; 4th, by omitting all operative procedures, even suture in wounds which have become so thoroughly occluded by plastic material that the contents of the bowel cannot be pressed through them; 5th, by operating first on those wounds which imperatively demand it, and leaving to the last those which may recover without operation; 6th, by never eviscerating a patient, except, first, when hemorrhage is otherwise uncontrollable, and second, when there is evidently a discharging wound which cannot otherwise be found. The evisceration of a patient is as dangerous as any gunshot-wound of the intestine which cannot be made to discharge its contents by manipulation or pressure can possibly be. There are cases when evisceration is necessary, but the author protested earnestly against the habit of eviscerating patients suffering from gunshot-wounds of the abdomen as a matter of routine. We are not warranted in turning a man inside out and subjecting him to frightful dangers in the mere fear that there may be still an undiscovered wound, when all the symptoms which ought to indicate such a wound are absent.

9. In cases of these wounds in which patients may be too weak to endure any radical operation for their repair, efforts for their relief may be made by incision and drainage, and in some cases by attaching the injured intestines to the abdominal wall as in gangrenous hernia. This procedure occupying but little time, and making no draft upon the strength of the patient, may offer a hope of recovery which would not be possible under the expectant mode of treatment.—*Med. Record*, June 1, 1889.

Successful Resection for Rupture of Intestine.—On the morning of Wednesday, May 22d, Mr. Croft operated on a boy aged fourteen for ruptured intestine without external wound. Fifteen hours and a half before Mr. Croft saw the boy the latter had been kicked by a horse in the region between the umbilicus and pubes. Acute septic peritonitis was diagnosed, and laparotomy was immediately performed. A rupture of about three eighths of an inch in diameter was discovered in the small intestine. It was believed to be in the lower end of the jejunum or upper part of the ileum. The contusion about the rupture was nearly an inch across. The opposite wall of the gut was also contused. The parts were bathed in feculent inflammation products. A segment of the bowel was cut out; this was about two inches and a quarter long at its unattached border, and about half an inch at its mesenteric border. An enterorraphy was carefully completed, Lembert's sutures in a single row being employed—about thirty-five sutures in all. The peritoneal cavity and all tainted surfaces were carefully purified with warm boracic solutions. The abdominal incision was closed in the usual manner. The temperature before operation had been 103.6°; it fell in three hours to 98.2°; it rose during the night to 100.4°, and afterwards steadily declined. Since the night of the second day it has been normal or subnormal. The sutures were removed from the abdominal wound on the seventh day, when the boy was taking an ounce of fluid nourishment by the mouth. He may now be pronounced convalescent.—*Lancet*, June 1, 1889.

Ruggi on Resection of the Liver.—A woman presented herself with a bi-lobed tumor in the right hypochondriac region, which by percussion appeared to be covered with intestine. A hydatid cyst of the kidney was suspected. The author performed laparotomy, and found two enormous echinococcus cysts in the liver, one anterior and superficial, the other posterior and deep. He enucleated them and then tried to unite the sides of the large opening which had been made in the liver; but was unsuccessful. He then resected three inches of liver tissue so as to make the cut regular, and fixed the surface of the liver to the border of the abdominal parietes. In the first few days he was obliged to change the dressing very often, on account of the persistent flow of bile which escaped from the cut section of the liver; but gradually this secretion diminished, and the patient recovered.—*Med. and Surg. Reporter*, June 1, 1889.

Dundore (C. A.) on Gunshot Wound of Sacrum, Penetrating Abdomen, with Protrusion of Bowel.—On Sept. 26th, two days before admission, while the patient, a boy of nineteen, and several companions were gunning, the weapon of one of his friends back of him was accidentally discharged, and the greater part of the load of No. 4 shot lodged in his back, a portion of the charge striking and shattering the handle of a hatchet which the patient had stuck through a belt at his back.

At the time of his admission, which was about 36 hours after the accident, the patient was suffering slightly from shock, and his temperature was 101°, his pulse 100, and respiration 22. A slightly lacerated and contused portion of bowel protruded by the rough edges of the shattered sacrum, but there was no evidence of puncture.

The wound being constantly irrigated with a 1 to 1,000 solution of bichloride of mercury, the bowel was replaced without any trouble. The sacrum was found to be shattered on each side of the vertebral canal, and on each side of which it was possible to insert two fingers entirely through the body of the bone. The cord was protected merely by a thin sheath of bone on each side. The spicula of bone and the shot remaining in the wound were carefully searched for and removed; a glass drainage-tube was then inserted and the wound dressed antiseptically.

The only interruption to speedy convalescence was a diarrhœal attack which finally yielded to nitrate of silver.—*Coll. and Clin. Record*, June, 1889.

Mastin (C. H.) on a Comparison of the Various Methods Adopted for the Radical Cure of Hernia.—The ligature of the sac at its neck, with suture of the pillars of canal and ring, may be considered an established surgical procedure; still being a comparatively new operation, a discussion of its merits will be of practical value in leading to further improvements, and with them permanent success of the operation. With the present lights before us, the most important point in the operation appears to be closing the

neck of the sac as high up as possible, so as to effectually seal up the opening into the abdominal cavity. To do this completely it is necessary that the sac should be carefully separated from the adjacent tissues, and this is not always an easy matter, since oftentimes the true sac is obliterated and a new sac formed in the fibrous tissue, with the vascular and nervous distribution blended in such a manner as to render the dissection most difficult, if not impossible. In such a case MacEwen's operation could not be performed, and it would be impossible to twist the sac as recommended by Mr. Ball. This objection does not obtain in crural and umbilical herniæ, still since inguinal is the most frequent of the herniæ, it is of importance in them. In congenital cases it is much easier to separate the sac, and hence more possible to do a complete operation; but since, in young children, the truss properly applied and long continued, until the abdominal parieties have been so developed as to increase the obliquity of the canal, will in most instances produce a permanent cure, all operative procedures in children should be considered unwarrantable. In those cases, however, where an imprisoned testicle complicates the condition, the operation is unquestionably proper and the removal of the testicle justifiable, and for the simple reason that the presence of the gland in the canal predisposes to the descent of the hernia.

Since the main point in the success of the operation appears to have been the proper disposal of the sac, it is not astonishing that operators who have given it their attention should have adopted diverse methods, each one of which has the same end in view. Whilst Ball twists it, MacEwen tucks it up; Hardee insists upon the importance of inclosing the transversalis fascia with the sac in the ligature; J. D. Bryant splits the pillars on either side and weaves in the sac; Annandale opens the canal, ties the sac, cuts it away, and stitches the opening; on the other hand, Stokes opens the sac, and then stitching the neck, the canal, and the pillars together, he leaves the sac in position; Banks opens the sac, ligates the neck, cuts away the fundus, and sutures the pillars; Alexander, of Liverpool, opens the canal, ligatures the sac flush with the peritoneum internally, then divides the neck below the ligature, leaving the sac in the canal without suturing the ring; MacCormac advocates this plan, while Buchanan cuts down to the sac, slits it up longitudinally on each side of the cord, divides the front part horizontally, rolls up the upper part, with which he plugs the internal ring, and turns down the lower half to form the tunica vaginalis.

From a comparison of all the methods it is apparent that no fixed rule of procedure is established, and although the radical operation is a marked improvement in the treatment of hernia, whether free or stangulated, we cannot consider it perfected, because the methods hitherto resorted to have not proved radical in results. The operation is ideally correct, but the question arises whether, with the uncertainty of success, the risk justifies the operation, especially so if the circumstances of the individual are such that he can content himself with the use of a properly adjusted truss.—*Jour. Am. Med. Assoc.*, June 1, 1889.

MISCELLANY.

Richardson (M. H.) on the Surgical Treatment of Gangrenous Hernia.—The author concluded as follows: It seems to be the general opinion of surgeons everywhere that, under some circumstances, excision and suture are justifiable. It seems to me that the primary operation should only be done where all the conditions are favorable. It is preëminently a hospital operation. Every appliance and preparation should be ready for its most perfect performance. It is not an operation to be recommended to the general practitioner or to the unqualified operator. It depends for success more often upon rapid and skilful execution than almost any other operation.

There is no doubt that in some cases this procedure is imperative, where the part necrosed is too high up for intestinal nutrition to be maintained. The difficulty, of course, is to recognize this state of things. Even when it can be demonstated that the jejunum is gangrenous, excision is not justifiable unless the patient's condition offers some hope, and there is a chance that the relief of the symptoms of obstruction may be followed by sufficient improvement to make a second operation unnecessary.—*Jour. Am. Med. Assoc.*, June 1, 1889.

Coston (H. R.) on a Case of Dry Labor.—On the evening of April 13th I

was called to see a woman of twenty-three, supposed to be in labor with her second child. I found the uterine contractions very short and irregular. Upon making a vaginal examination I found the pelvis large and roomy, the soft parts lax and well lubricated, but no dilatation of the os. The symptoms soon passed off, and labor did not supervene for over two weeks. But upon this first visit I was surprised to learn that the membranes had ruptured on the night of the 16th of March. I expressed the hope that this had been an extra-amniotic sac, and that there was probably a small amount of water yet present, as the movements of the child were very free and strong. She informed me, however, that her "waters had broken ten days before labor came on in her first pregnancy." She attributed the rupture of the membranes in her first pregnancy to a strain received while trying to use the syringe for the purpose of evacuating the bowels, as they ruptured while she was in the act of giving herself an injection.

In the present instance, however, they had ruptured during sleep,she being aroused by it, herself and husband as well as the bedding being wet by the fluid, there being a considerable quantity. No symptoms of labor presenting themselves save the rupture of the membranes, and remembering her first experience, she had called no physician at the time. Feeling greatly interested in the case, the patient being quite an intelligent women, and living next door to my office, I gave the case close attention until the time that labor developed, April 30th.

The labor only lasted about three hours and a half, and during the time I never left the bedside a moment for any thing whatever. During the progress of labor there was no pouch found, and through the dilating os uteri I could determine positively that there was no membrane of any kind between my finger and the occiput. A portion of the membranes were expelled some minutes before the child was born, which further convinced me that the membranes had long since ruptured.

In this case we find that it was about forty-five days from the time the membranes ruptured until labor commenced.

Yet when it did come on it was comparatively short and easy, there being but a small amount of blood lost and an eight-pound male child born. Up to this writing (May 7th) there has never been a bad symptom developed, the mother rapidly regaining her strength and the child doing well.—*N. Y. Med. Jour.*, May 25, 1889.

Shrady (J.) on Signs of the Moribund Condition.—The conclusions of the writer are:

1. That in general the signs of death that are the most trustworthy appeal to the eye.

2. That among these the respiratory function holds the first rank, both in cases of coma and asthenia, more noticeably when the two modes of death are blended.

3. That the death by coma represents, in duration, the longest period.

4. That the most valuable sign of inevitable dissolution is the up-and-down movement of the pomum Adami, always providing that it be persistent.

5. That temperature changes deserve recognition, particularly when the curves are sharp, high, and continuous, or when they are below the normal.

6. That an intermittent pulse is an early sign of death, especially when not due to any disturbed action of the nervous system. The qualification necessary to save this statement from being absolute lies in the fact that occasionally individuals are found who maintain this peculiarity through a long, healthful life.

7. That deaths from syncope are too sudden to allow of much observation or study.—*Med. Record*, June 8, 1889.

Willoughby (E. F.) on Phenol in the Treatment of the Vomiting of Pregnancy.—One remedy only has in my hands proved almost, or I may say invariably, successful. This is phenol. Formerly I used creasote, but it had the great objection of scanty solubility in water, even with the aid of spirits of chloroform and glycerine; but pure phenol is perfectly soluble in water without any addition. The dose I give is one grain in half an ounce or one ounce of water ever four hours or less often, and I can state that it has never disappointed me, permanently relieving the symptoms in most cases after two to four days, and rarely requiring to be resumed. I have found it scarcely, if at all, less valuable in other reflex vomiting, as that of aural and stomachal vertigo, and in several cases in which I have recently tried it, of the vomiting following subcutaneous injections of morphia. I am anxious to observe its effect in sea-sickness.—*Lancet*, June 1, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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RECENT FRENCH CONTRIBUTIONS TO PATHOLOGY.

Roux and Yersin on Experimental Diphtheritic Paralysis.—The authors introduced living cultures and filtered cultures of the bacillus of diphtheria by intravenous, intrapharyngeal, or intratracheal routes, into the system of healthy animals.

They find that it is principally in those animals which do not succumb too quickly to the intoxication that paralytic symptoms show themselves. In a pigeon, for instance, paralysis commenced three weeks after inoculation, when the animal, free from false membranes, appeared completely recovered. The functional impotence of the feet and wings was almost complete, and death supervened two days after the supervention of these symptoms, the nervous system on autopsy showing no lesions which would explain the symptoms. In the rabbit, paralysis commenced generally in the hind legs, and in rapidly progressive cases invaded in two or three days the whole body. In some cases there was paralysis of muscles of the neck with inability to raise the head; in others there was paralysis of the muscles of the larynx with hoarseness. In some cases the respiration was diaphragmatic and jerky, any exertion bringing on oppression and asphyxia. Sudden death without convulsions was sometimes seen.—*La Tribune Méd.*, March 7, 1889.

Hallion (L.) on Infantile Paralysis; Purpura Localized in the Atrophied Member.—The patient was a man of thirty. At the age of two he had infantile paralysis, which brought about a retarded development of the left leg. At the age of seventeen he developed a hemorrhagic tendency, bleeding profusely at intervals from the nose and ears. After many recurrences of these hemorrhages he noticed one evening a purplish eruption upon the wasted leg, and later there came on burning sensations and darting pains in the same location. The eruption became more and more extensive, was aggravated by walking and relieved by recumbent posture. The sensibility of the limb was good, and there was no other vascular disturbance.—*Le Courrier Médical*, May 11, 1889.

Libouroux on Sudden Death in the Course of Typhoid Fever from Hemorrhage in the Medulla—A soldier of twenty-four died suddenly on the twentieth day of typhoid fever. The temperature had been pretty high, and large doses of quinine and antipyrin had been given. On the sixteenth day some pulmonary symptoms developed. Indications of improvement appeared, when at 5 P.M., on the twentieth day, a sudden agitation seized the upper extremities. Trismus appeared simultaneously, the patient turned over on his face, took several deep inspirations, and became cold. The face and mucous membranes became cyanosed, and death occurred in fifteen minutes. At the autopsy all the ordinary lesions of typhoid fever were found. Besides these, there was found in the upper and middle part of the fourth ventricle a hemorrhagic focus the size of a lentil. The legion was located in the point of origin of the pneumo-

gastric nerve.—*Gaz. Hebd. des Sci. Méd. de Bordeaux*, May 5, 1889.

Lop (P.-A.) on a Case of Tetanus Neonatorum of Microbian Origin.—On the tenth day the child showed tetanic symptoms. Death occurred on the eighteenth day, the course of the disease being typical of tetanus neonatorum.

At the autopsy the umbilical wound was found completely cicatrized, there being just a drop of pus beneath the cicatrix. The spinal cord was not congested, nor were there meningeal hemorrhages.

With the help of Prof. Rietsch, the author studied the case experimentally, as follows: Pieces of the child's spinal cord introduced under the skin of adult guinea-pigs produced no disease of any kind.

Other animals, inoculated with the pus from the umbilical scar, died of septicæmia, having, early in the poisoning, some contracture of the limb nearest the point of inoculation. A culture, made from the same pus, developed numerous bacilli which, when inoculated in healthy animals, produced in 48 hours very marked tetanic symptoms, which, finally, passed entirely away.

On close questioning, it was found that the mother had washed the cloths, with which the umbilical cord had been dressed, at a sort of stagnant pool, and some mud from this pool was introduced under the skin of several animals, all of which died of tetanic symptoms.

Pus taken from the point of inoculation of these animals was cultivated, and cultures of the resulting bacteria produced death in three days, with tetanic symptoms. —*Marseille Méd.*, March 30, 1889.

Sée (G.) and Gley (E.) on Experimental Diabetes.—Diabetes is brought about in two ways by these experimenters: First they have found that an excitation of the central end of the vagus nerve will cause hyperglycæmia and glycosuria. In animals where this excitation was kept up continuously, there was also an increased excretion of urea, and marked and rapid emaciation. Their other mode of producing diabetes is by causing animals to ingest daily a certain quantity of phloridzine ($C^{21}H^{24}O^{10}$), in the proportion of 1 to 10 to the weight of the animal. This substance is a glucocide, extracted from the bark of the root of different fruit trees. Under this treatment the urine of animals becomes diabetic at once, and contains from 10 to 20 per cent. of glucose. The glycosuria ceases with the cessation of the drug. Upon animals thus made diabetic, the experimenters tried various remedies. Bicarbonate of soda and arsenic seemed ineffectual. Bromide of potassium produced a slight diminution of glucose. By far the best results followed the administration of antipyrin.—*La France Méd.*, Jan. 22, 1889.

Joffroy on the Relations between Progressive Locomotor Ataxia and Exophthalmic Goitre.—The author has encountered among ataxics all the characteristic symptoms of Basedow's disease: exophthalmus, rapid pulse, goitre, tremor of the hands, etc., etc. He frequently finds some one of these symptoms present, the rapid pulse being most frequently observed. After a careful study of the subject Joffroy concludes that the simultaneous presence of the two diseases is a coincidence, although ataxics may develop a rapid pulse and a prominence of the eyes, recalling certain abortive forms of Basedow's disease.—*L'Union Méd.*, Dec. 18, 1888.

Pluyette (E.) on Two Rare Complications of Diabetes.—A man of forty, who had had syphilis developed diabetes, passing about three quarts of water daily, containing from two to three ounces of sugar. Signs of pleurisy developed and he was tapped, with the result of drawing off three pints of a greenish fluid from the left pleural cavity. This fluid contained a small percentage of sugar. Signs of pulmonary tuberculosis soon appeared, and later still a violently painful intercostal herpes zoster at the base of the left side of the chest.—*Marseille Méd.*, March 30, 1889.

Verneuil and Clado on the Presence of Microbes in Congenital Dermoid Cysts of the Face.—Three times out of four the authors have found microorganisms in congenital dermoid cysts. In two cases, boys of fourteen and sixteen, the cyst was situated in the floor of the mouth, in one case in the eyebrow of a man of twenty-two. All precautions were employed to make removal of the cysts and their contents aseptic. In one case was found a bacillus like that of typhoid fever, in the others micrococci abounded. The cysts at the time of their removal were indolent and, being of intra-uterine formation, must have received their mi-

crobes in some way, from the circulation.—*La France Méd.*, December 25, 1888.

Firket on Syphilitic Alterations of the Cardiac Valves.—A woman of fifty-three died of marasmus, entirely œdematous. The autopsy showed numerous gummata of the liver and amyloid degeneration of the kidneys and spleen. Near the free border of the large fold of the mitral valve was a thrombus which adhered closely to the valvular surface. A microscopic examination of the valve in question showed large areas of amyloid deposit occupying nearly the entire thickness of the valve. Upon the upper surface of the valve the degenerated zone had reached the surface and destroyed the endothelium, and to this naked surface the thrombus had adhered.—*Annales de la Soc. Méd.-Chir. de Liége*, February, 1889.

Huchard on Subcutaneous Emphysema in the Course of a Pneumonia in a Malarial Patient.—A boy of five had a pneumonia of the lower lobe of the left lung.

On the second visit it was found that the boy had an emphysema occupying the side of the face, the mastoid region, and the front part of the neck and chest. This was very surprising as the child had had almost no cough. Later a "congestive" pneumonia developed on the right side. A history of previous intermittent fever was elicited and quinine was given hypodermically with the result of bringing about recovery on the twenty-first day.—*La Tribune Méd.*, May 2, 1889.

Sanchez-Toledo on the Transmission of Tuberculosis from Mother to Fœtus.—The author's experiments, include 35 adult female guinea-pigs and 65 of their offspring.

Pure cultures of Koch's bacillus were injected in different instances into veins, pleural cavities, and subcutaneously in pregnant females, and while it was found that almost invariably the mothers became tubercular, in no instance did the fœtus *in utero* become infected with tubercular disease.[1]

MM. Malvoz and Browvier have lately demonstrated, according to the *Lancet*, June 8, 1889, the occurrence of tubercle bacilli in a fœtal calf, and afford proof of the actual transmission of the tubercular virus from the maternal to the fœtal organism. One of their specimens was from an eight-months' fœtus found in the uterus of a tuberculous cow. The liver contained numerous grayish-white granulations, and small cretaceous yellowish points were found in the centre of the lymphatic glands at the hilus of the liver and root of the lung. Sections of each of these parts displayed well marked giant cells and numerous bacilli. In another case—that of a calf of six weeks—similar but more advanced lesions were found.

[On consulting the original article, which appeared in the *Annales de la Soc. Méd.-Chir. de Liége*, March, 1889, it is seen that in the cases of Malvoz and Browvier the mothers (cows) were naturally tubercular, which fact places them beyond comparison with the subjects of Sanchez-Toledo, where tuberculosis was artificially produced in animals which very readily develop tubercular disease.—ED.]

Wacquez on Primary Cancer of the Lung.—The patient was a man of forty-six, with no hereditary taint.

In August, 1887, while in apparent health, he suddenly, during the night, expectorated several clots of coagulated blood. Some days later another hæmoptysis occurred. After this, bleeding frequently recurred, and became more profuse, the patient getting thin and weak. The sputum resembled currant jelly. A slight sweat, occasional fever, and no disturbance of the alimentary canal, such was the history of the case up to the end of 1888.

In January, 1889, the general condition became much worse. There were severe pains along the spine, and about the base of the chest. Violent cough and dyspnœa, with great general weakness.

On the left side of the chest there was dulness and complete absence of vesicular murmur; behind there was dulness, with a soft respiratory murmur at the base. There was no egophony. An aspirator needle withdrew only a bloody fluid. There was no fever. Death occurred March 1st. An autopsy showed the base of the left lung to be crowded back by an old bloody serous exudation. The pleura was thick and fibrous. The two upper thirds of the lung were invaded by friable tissue of an encephaloid appearance, in the substance of which were several irregular cavities. The upper lobe was transformed into a solid mass of a grayish-white color. The lesions

[1] *Gaz. Hebd. des Sci. Méd. de Montpel.*, May 25, 1889.

of the pleura were simply inflammatory in their nature.

Neighboring ganglia were not invaded. A dozen cancerous nodules were scattered on the surface of the left lung.

The only other organ affected was the left suprarenal capsule, which was thrice its normal size and encephaloid-looking.—*Jour. des Sci. Méd. de Lille*, April 26, 1889.

THERAPEUTICS.

Doyon (M.) on the Accumulation of Bromide of Potassium in the Organism.—Rabuteau has shown that while the larger part of each dose of the bromide of potassium is eliminated in a day, a small portion remains to be much more slowly cast off from the organism, hence by continuous administration the drug becomes cummulative.

A boy of 12 had been a year under treatment for an epilepsy complicated by spells of furious mania. During this year he had taken large doses of the bromide of potassium 60, 90, and even 120 grains a day.

November 24, 1888, he contracted scarlet-fever, which developed normally, but on the first day of his admission to the hospital he was seized with attacks of epilepsy and furious mania. In the intervals of the attack he was speechless and completely prostrated and the bromide was stopped, but as the attacks came on with redoubled violence, it was resumed, in 60-grain doses.

In a few days the patient began to cough and have suffocative attacks with a high temperature, and Dec. 11th, he died.

At the autopsy the brain seemed unusually hard, the lungs congested, and other viscera normal. The brain and the liver were subjected to a quantitative analysis for the bromide and there were found in the brain 30 grains and in the liver 12 grains.—*Lyon Méd.*, March 31, 1889.

Spender (J. K.) on the Hydrate of Chloral.—The author is one of those who think that chloral is an unjustly neglected and unnecessarily feared drug. He estimates invaluable and safe in delirium tremens.

A woman under his care had abused alcohol for years and was suffering all the horrors and terrors of alcoholic poisoning. Physically, she was pretty well except she suffered from syncopal attacks. Fearing the action of chloral upon the heart, opium, with warm liquid food, was first given with the result of not in the least allaying the sleeplessness and frenzy.

In the next nine days 13 drachms and 20 grains of chloral were administered, at first 20 grains every three hours, then every four or five hours, and later irregularly as needed. At the earliest stage of treatment there came tranquillity; then profound, though broken sleep; the sleep became more continuous with perseverance in the chloral; by degrees the medicine was withdrawn, and the waking intervals were more and more sane; food was plentifully taken in the shape of eggs, broths, and milk with soda-water *ad libitum*. Ordinary health seemed quite restored on the ninth day. A subsequent attack of the same kind of illness was treated successfully in the same way. The author says:

"For the special delirium of acute alcoholic intoxication, chloral is the supreme remedy. My contention is, that there is no room for a scrap of doubt about it. A medical man who neglects it, or declines to use it, sins against certain knowledge; nor is he less a sinner if he goes back to opium or digitalis, or any other empirical stuff which has been luckily buried and forgotten. The absolute certainties of medical art are mournfully few, and we ought so much the more to value those we have."

The author thinks it better than any other remedy in chorea. The beginning of the chloral treatment of chorea is associated, he tells us, with what was nearly a tragedy. To a girl, aged eight, suffering from the disease in an aggravated form, a nurse gave by mistake one night 45 grains of chloral; most alarming symptoms ensued, and the life of the little patient was in extreme jeopardy for some hours. There was an immediate improvement, however, in the choreic symptoms: and in the course of another day there was a complete and permanent cure. Such is the story published by Dr. Gairdner in *Glasgow Medical Journal* for 1870. Emboldened by this happy accident, Dr. Bridges (*Practitioner*, March, 1877) urged that chloral should be given for chorea in doses that will cause sound sleep. The principle guiding us ought to be this: the patient must have ten hours' sleep in the twenty-four. The disease is naturally suspended during sleep, and therefore a drug which produces sleep is plainly indicated. A

dose of 3 ss. is administered; this may have to be repeated, or half as much, or less, if the patient does not sleep. Immediately on awaking another dose is given, less or more as the patient had slept well or ill; and on waking again, another dose, less than the one before, and so until the amount of sleep required had been obtained. The chloral is then discontinued until the following night. By this ingenious plan Dr. Bridges tells us that he cured two bad cases—the first within twenty-four hours, the other within three days. Dr. Day reports rapid success in acute chorea by prescribing 10 grains of chloral every two hours."

He also appreciates the immense advantage accruing from the addition of chloral to a mixture of the bromides in epilepsy.

In pain of a minor grade of severity, he finds that a small dose (5 grains) every hour, is sometimes of great benefit. After speaking of its use in migraine, malignant disease, as a substitute for chloroform in labor and in different ailments of the respiratory and digestive tract, he says: "The evidence is tolerably unaminous that the therapeutic virtue of chloral does not suffer by frequent repetition.

"There is an ethical element in chloral, alcohol, and opium which demands a weighty consideration. The perverted use of these substances may destroy self-control, and finally overthrow the moral and intellectual faculties. And so the casuists say that a huge responsibility rests on the adviser who prescribes chloral or alcohol or opium, lest haply they may be abused through ignorance or morbid craving. Undoubtedly. But the man who does not shrink from duty is never afraid of responsibility. If the necessity arises, the necessity must be met. The wise physician studies the "environments" of his client, and especially the force of his character. The "poison of misused wine" has been the theme of poetry as well as the lament of psychology; and who would deliberately put the weak man or woman in the way of temptation? But if we are to strike out of the Pharmacopœia all the things which weak men and women have abused, our best traditions are made of none effect, and the reign of Timid Medicine begins."—*Bristol Medico-Chir. Jour.*, March, 1889.

Mairet on the Therapeutic Effect of Sulphonal.—The author has used this drug as an hypnotic with excellent results. He has, however, seen disagreeable effects follow its use for several consecutive days, viz., intoxication, unsteadiness, mental weakness, nausea, vomiting, etc., which compelled him to suspend the treatment after three or four days. After some experience these disagreeable symptoms can be avoided by an appropriate alternation of administration and omission of the remedy.—*Gaz. Hebd. des Sci. Méd. de Montpellier*, March 23, 1889.

Stevens (J. J.) on the Value of Apomorphia as an Antispasmodic.—A married woman, of thirty, the mother of six children, had been subject to violent attacks of hysteria for ten years. They consisted of opisthotonos and rigidity of the muscles of the entire trunk. The eyes were wide open and pupils dilated. Intense pain in the head commences with the attack, and lasts entirely through it. Consciousness is only partially retained. The crises lasted two to three hours, and recurred at short intervals for several days.

Chloral, chloroform, and the bromides gave little, if any, relief.

In July, 1888, $\frac{1}{10}$ gr. hydrochlorate of apomorphine was injected, with the production, in seven minutes, of copious vomiting and relaxation, and complete relief. In January, 1889, in another attack, $\frac{1}{10}$ gr. of apomorphine, with $\frac{1}{8}$ gr. sulphite of sodium was given, and she has had no attack since.—*St. Louis Med. and Surg. Jour.*, June, 1889.

Comby (J.) on Acute Right-Sided Pleurisy; Treatment by Caffeine; Rapid Recovery.—A man of twenty-seven had had symptoms of pleurisy for twelve days. The physical signs were characteristic. He was put on milk diet and a potion containing 19 grains each of caffeine and the benzoate of soda. He took these doses 12 days without discomfort. The urine before treatment was scanty (20 oz.) and high-colored; at once became clearer and rapidly increased in amount, reaching at last four pints in twenty-four hours.

The symptoms of pleurisy rapidly vanished, and the patient left the hospital well three weeks after admission.—*La France Méd.*, April 4, 1889.

Grandclément on Indications and Dangers of Antipyrin.—A man of sixty-five with double chronic glaucoma had violent headaches every four or five weeks, lasting twenty-four to thirty-six hours. For

a year he stopped them invariably by taking one or two 9-grain powders of antipyrin. For the last four months every time he took the medicine the skin on the backs of his hands, about the eyes and about the arms, became covered with ecchymotic patches five-eighths inch in diameter. After the last dose of the medicine the patches were larger, became confluent, and did not disappear for eight to ten days. No other disagreeable effect was noticed. — *Lyon Méd.*, March 17, 1889.

Atkinson (F. P.) on Quinine in Pulmonary Inflammations. — In pneumonia, broncho-pneumonia, pleurisy, and whooping-cough, I give quinine in small and oft-repeated doses. For instance, in the case of adults, I give three grains dissolved in a little dilute hydrobromic acid every three or four hours. I have given a quarter of a grain to an infant six weeks old every four hours, with very manifest advantage. It should be given either immediately before or after food, otherwise it is apt to cause sickness. In the case of pneumonia in particular, if there is much headache in the early stages, I combine with the quinine three or four minims of the tincture of digitalis. If the skin keeps hot and dry, and the urine is loaded with urates, it is as well to give a little "effervescing citrate of potash," combined with some sweet spirits of nitre, alternately with the quinine ; but this should be stopped as soon as diaphoresis occurs. Brandy in tablespoonful doses every four hours is advisable from the start. In the case of pleurisy, the combination of morphine is necessary, and the use of a little gray powder often proves very useful. As regards the effects of quinine, it will be found that perspiration occurs after each successive dose, and this no doubt is brought about by its action on the vaso-motor system of nerves. In whooping-cough it perhaps acts antiseptically on the germs, which have their habitat in the upper part of the pharynx. I would say that quinine is a safer antipyretic than antipyrin, antifebrin, or phenacetin, and this naturally produces a bias in its favor. I believe it shortens the duration of pneumonia, and certainly in the case of infants many cases that in old days would have been considered perfectly hopeless now make a good and quick recovery. A friend of mine tells me that since he began the quinine treatment of pneumonia five or six years ago, he has not lost a single case, though he has a mixed practice, and thus is not favored with the advantages which some possess. The value of quinine in whooping-cough is most marked, for it undoubtedly controls the spasms, and, I am inclined to think, also shortens the duration of the disease. At any rate with its use inhalations are entirely unnecessary, and there is never that prostration which in some cases results from the use of bromides and belladonna. Where there is much secretion, or an apparent loss of nerve-power, the combination with it of the syrup of the lactophosphate of lime proves of great service.—*Practitioner*, June, 1889.

Hoffman (R.) on the Treatment of Chronic Diarrhœa by the Internal Administration of the Silicate of Magnesium.—Following the communication of Debove on his success in the treatment of chronic diarrhœa by the internal administration of magnesium silicate in daily doses of about 6 to 18 drachms, I have made use of this agent in five cases of chronic intestinal catarrh (enterocolitis) with marked success. They were all cases of chronic diarrhœa in adults who for weeks had had 15 to 30 strongly fetid evacuations a day. One case was probably a tuberculous affection of the intestines, but even in this case a striking improvement was noticed from the use of this drug. After having treated the first case it seemed to me as if the effect of the powder was more marked, the nearer it was brought in immediate contact with the thoroughly cleansed intestinal mucous membrane, therefore I made use of the following method of treatment which I can heartily recommend.

The nourishment consisted exclusively of milk, yolk of eggs cooked soft, light soups, and finely cut uncooked meat. For the first three days of the treatment I had 3 j of naphthalin given in doses of gr. viiss, each. At the same time 2 qts. of tepid water were injected into the rectum according to the method of Hegar, and this the patient held for five minutes and then passed. Immediately after the patient was put in the knee-elbow position and turned on the side and the following was injected into the rectum :

℞ Carbolic acid
Alcohol āā 1.0. (15 minims.)
Tepid water 1.000 (2 qts.)

This was also held five minutes and

passed. With this treatment the foul odor was weaker on the second day, but the number of evacuations was only slightly affected. On the fourth day 6 to 9 drachms of powdered magnesium silicate were given suspended in 2 qts. of milk, and this was done with no discomfort to the patient who never complained at the size of the powder. The same dose and also the irrigations were kept up for two or three days, and sometimes the irrigations lasted longer. After the first day's dose of 6 to 9 drachms of magnesium silicate the evacuations decreased in number from 20 and 30 to 10 and 15, and after each irrigation they were from 3 to 5 fewer. At the same time the yellow color of the fæces disappeared; these took on their natural color and compact form. The magnesium silicate was passed as such within twenty-four hours, and without any injurious effect. I should like to remark in conclusion that in these five grave cases every possible astringent and opiate had been used for weeks without success and the striking result could only be ascribed to the magnesium silicate.—*Maryland Med. Jour.*, June 15, 1889.

Crolas and Hugounenq on the Physiological Effects of Antipyrin.—Antipyrin continued for forty days in from 75- to 150-grain daily doses produced in dogs a sensible diminution in the number of red blood corpuscles with no positive changes in spectroscopic appearances. The experimenters found it impossible to determine its effect on the amount of urine excreted, but were convinced that it increased the flow of urea, while the phosphoric acid remained about stationary. The process of oxidation, as denoted by the urinary excretions, seemed to the authors to be unaffected by the drug. In all their experiments the authors saw no toxic action of the drug.—*Lyon Méd.*, March 3, 1889.

Paul (C.) on the Antiseptic Power of Saccharin.—Finding saccharin destructive of certain microbes, particularly the streptococcus pyogenes and the different organisms of the mouth which liquefy gelatine, the author proposes the drug as an ingredient of an antiseptic dentifrice. He recognizes the fact that it has no power over the germs of typhoid or puerperal fever. At his suggestion, Trousseau has tried the drug as an ocular antiseptic in $\frac{1}{100}$ or $\frac{1}{200}$ solution, and has found it equally efficient as boric acid. The solutions are well tolerated and absolutely innocuous.—*Le Praticien*, Dec. 24, 1888.

Gorecki on Treatment of Infectious Ulcers of the Cornea by Chlorine Water.—The author first dilates the pupil by a $\frac{1}{4}$ per cent. solution of neutral sulphate of atropia, and then anæsthetizes the cornea by a $\frac{1}{20}$ solution of hydrochlorate of cocaine. He then, with a fine hair pencil, touches the ulcer several times with a saturated watery solution of chlorine, taking care to thoroughly reach the base of the ulcer, but not to allow the chlorine water to spread upon the healthy conjunctiva. He then orders an eye-wash of hot boric solution, and the application of a light bandage. If there is a hypopyon, he orders 2½ grains of calomel in ten doses at half-hour intervals, in sweetened water. In some cases it is well to employ inunctions of mercurial ointment for a time.

It is rare that an ulcer requires more than three daily touchings before it is healing.

The author lays stress on the necessity of dilating the pupil well, and being sure of having well-prepared chlorine water.—*Le Praticien*, Dec. 17, 1888.

MISCELLANY.

Stevens (L. T.) on a Case of Mitral Stenosis Complicated by Pregnancy, Presenting an Asthma of Probable Utero-reflex Origin.—The patient had rheumatism followed by chorea, at the age of 16. When 20 she become pregnant and chorea again set in, to disappear at delivery. The child was puny, and died of convulsions when six weeks old. A year later she became pregnant, and in the third month was taken with dyspnœa, palpitation, cough, and spitting of blood, all of which symptoms disappeared on the birth of a four-pound child, which lived two years and died of diphtheria. In a third pregnancy she had the same symptoms as in the preceding, except that they were more severe and accompanied by anæmia orthopnœa and œdema of the lower extremities. This child weighed three pounds, and died in a few days. In about a year she became pregnant again, with similar but worse symptoms, and a superadded asthma, which came on at dusk and increased in severity until midnight, when it rapidly subsided. A bad cough troubled her all the time.

The heart was evidently much enlarged, its action tumultuous and irregular; there was a loud, presystolic, purring murmur over the apex, and accentuation and reduplication of the second sound in the pulmonic area. There was a little albumen in the urine. The uterus was enlarged and could just be felt above the pubes. All sorts of remedies were tried, but at last resort had to be had to induction of premature labor, by means of which a fœtus seven inches long was expelled, and all bad symptoms checked at once. The relief afforded was permanent.—*Weekly Med. Rev.*, May 4, 1889.

St. Bonnet on Ablation of Suppurating Vulvo-Vaginal Glands during Pregnancy.—A woman of 20 acquired a gonorrhœal vaginitis in May, 1887. Both vulvo-vaginal glands became infected and the seat of abscess, one sooner than the other. In spite of the fact that the woman when seen was in the third month of pregnancy, the glands were completely eradicated with antiseptic precautions. From that time until confinement antiseptic douches of corrosive sublimate were daily used, parturition passed off normally, and the child was healthy, having no conjunctivitis.—*La France Méd.*, May 28, 1889.

DeBeck (D.) on Atrophy of the Optic Nerve Following Forceps Delivery.—A woman of 39 had marked divergent strabismus in the left eye, and the pupil was rather widely dilated. On attention being called to this, she stated that she had been blind from earliest infancy. Upon examination, the dilated pupil was found not to respond to the direct stimulus of light; the muscular control of the eye was poor; and the vision was entirely abolished, not even the mere perception of light being retained. The ophthalmoscope showed a typical white atrophy of the optic nerve. The disc was pearly white, sharply margined; the vessels were normal, and no changes were revealed over the entire fundus.

Two well-marked depressions, both long and narrow, were found in the cranium. The anterior one was over the left eye. It began about half an inch to the left of the median line, passed directly outwards about half an inch above the upper margin of the orbit, and was nearly an inch and a half in length. It was very decidedly depressed, being conspicuous to a casual glance across the room. Being so noticeable, it was a constant source of mortification to the morbidly sensitive woman.

The posterior depression began just to the right of the occipital protuberance, and ran directly outwards to the right. It was slightly over an inch and a half in length. It formed just about as deep a grove as the anterior depression.

The two depressions, as is at once seen, were thus diametrically opposite to each other.

The mother, over sixty years of age, stated that this had been her first child; that the labor had been very prolonged; and that finally, the forceps, a pair of large, heavy, old-fashioned ones, had been applied to finish the labor. The child's head had been badly bruised and distorted, but soon shaped up and healed. These depressions had been noticed at the time, and had remained ever since without any appreciable change.

The child had always enjoyed rather exceptionally good health. She had had a few "fits," but these seem from the descriptions to have been rather the ordinary reflex convulsions of childhood, than epileptic or epileptoid. She had not had chorea, or any neurosis, being only very sensitive about her conspicuous scar and squinting eye. The eye had always been perfectly blind.

The woman herself was found to be perfectly healthy, without any dyscrasia of any sort, and her children were well developed and perfectly healthy.

The history, and the position of the depressions, leave no doubt as to the forceps being the causal factor in the case. The blade sinking in over the eye would drive in the orbital plate of the frontal bone forming the roof of the orbit, or would so twist it, and with it the wing of the sphenoid, that firm pressure would be exerted upon the optic nerve in the optic foramen passing through this latter bone. Of a fracture we can hardly speak, the bones being too soft at this period. This pressure would result in the immediate destruction of vision, and in the consecutive development of a descending atrophy.—*Cincinnati Lancet-Clinic*, May 11, 1889.

Removal of Uterine Appendages Do Not Unsex.—E. M. Owens writes to the *Australasian Med. Gaz.*, of April, 1889, as follows: Whilst at work with Mr. Lawson Tait, he got me to make some enquiries

upon this point, from patients who had both ovaries removed. In not one could I get any history of diminished desire, but amongst many in whom it was decidedly increased were two very funny cases. The first was an old nurse about 45, who naively remarked in answer to my queries: "Well, I always did like it before I was operated upon, but now I never feel satisfied." The other case was a gentleman who consulted me whilst I was temporarily acting for Mr. Tait, he saying that since the operation there was no satisfying his wife, and much as he should have liked it had he been 25, but being past 50, it was rather too much, and what did I recommend should be done.

The Thymus in Cases of Sudden Death in the Water.—Dr. Nordmann, of Basle, describes a case of sudden death, while bathing, of a healthy young soldier, who, though a good swimmer, was seized with sudden rigidity and dyspnœa, sinking at once to the bottom. All attempts at restoration to life were fruitless. At the post-mortem examination nothing noteworthy was found, except an enlarged and hyperplasic thymus. Dr. Nordmann has since collected three other cases recorded by von Recklinghausen of sudden death in the water, and in all of them an enlarged and pathological thymus was found. Why an enlarged thymus, which had given rise to no symptoms during life, should suddenly cause death under the circumstances in question is not at all clear, but Dr. Nordmann suggests that it is possible that an acute swelling occurs in the gland, due to the collection of a large quantity of secretion in the follicles of the gland, similar to the condition observed by Friedleben during the process of digestion and assimilation.—*Lancet*, June 1, 1889.

Fitz and Whitney on a Malformed Heart.—The specimen was interesting because it represented a very severe malformation, and one which the patient was able to carry until reaching nearly the age of twenty, when she died of tuberculosis.

The history is briefly that of a cyanotic girl, who had been considered practically well. Although much discolored, and suffering from occasional circulatory disturbances, she was able to do all the ordinary housework on a country farm. She had attacks, characterized as "weakness" by her friends, which seemed to be of the nature of syncope. Six months ago she began to have pulmonary symptoms and to lose flesh. That has been progressive. Ten weeks ago she took to her bed. Then there was a sudden exacerbation of symptoms, with fever. From that time the progress has been rapid. After death there was a pronounced discoloration of the skin. The lungs were full of miliary tubercles. The interest of this specimen lies in the fact that it represents what has sometimes been called a heart with three ventricles. The condition is a stenosis near the origin of the pulmonary artery, resulting in the presence of an apparent small ventricular cavity from which the pulmonary artery arises, although it is really a part of the right ventricle cut off from the rest by the muscular trabeculæ. The heart is of about the normal size, but has a conspicuous enlargement of the right ventricle. Directly in front is the small ventricular cavity from which arises the pulmonary artery. It communicates with the dilated and hypertrophied right ventricle by a small opening large enough to admit the passage of a lead-pencil. The cavities of the right and left ventricles are comparatively normal, but the wall of the former is very much hypertrophied. The two ventricular cavities communicate by means of a defect in the interventricular septum, and the bulk of the blood which was forced out of the right ventricle went into the aorta, and was distributed through the general circulation. From the left ventricle the blood entered the aorta. The ductus arteriosus is closed. It is a matter of speculation as to the manner in which the pulmonary artery became distended with blood, for the pulmonary artery does not differ materially from the normal size. It presumably was accomplished by means of a dilatation of the bronchial arteries. The blood was evidently sufficiently aërated for this person to live in relative comfort for twenty years and die of tuberculosis.—*Boston Med. and Surg. Jour.*, June 6, 1889.

Lipomatosis of the Heart.—At a recent meeting of the Society of German Physicians of Prague, Prof. Kisch read some interesting notes on lipomatosis cordis. Prof. Kisch had performed a number of experiments for the purpose of finding out under what conditions the irregularities of the pulse occurred in those individuals who suffered from fattiness of the heart without presenting any other cardiac affection. Adipositas cordis and arhythmia of the pulse were rarely found in combinations.

Among the syphgmograms of 700 persons' arhythmi-cardiac activity could be met with in only 55 cases, *i. e.*, 8 per cent. In the case of juvenile individuals and those of middle age, the so-called cardiac intermittence ("Herzintermittenz") could be detected very frequently; it consisted in that a pause of rest occurred after a number of quite regular pulsations. This pause may supervene in a regular way, as for instance after each third or twentieth beat of the heart, or it may also be observed to occur quite irregularly. The pulse-curves offered the character of the pulsus tardus. The frequency of the pulse was most retarded, and the subjective disturbances were very slight. The lecturer had observed such an intermittence for several years, and treated it with success. In another series of patients who suffered from adiposity of the heart, and who, for the greatest part, had passed the fiftieth year of age, the arhythmia consisted in the fact that a number of regular pulses were followed by rudimentary pulses and pauses of rest. An increase of the area of percussion dulness and a slight beat of the apex of the heart were to be stated on the examination of these patients. When these patients made muscular exertions they became attacked with palpitations of the heart and dyspnœa; attacks of asthma, congestions in the venous system, and albuminuria, were also observed. That complex group of symptoms in which the pulsations followed each other quite irregularly and continually changed their frequency (delirium cordis) was to be observed only in those individuals who suffered from considerable weakness of the heart. The disturbances were very severe; dyspnœa occurred independently of the movements; asthenia, angina pectoris, œdema, albuminuria, general dropsy, and heart murmurs could be proved to be present. These symptoms never disappeared. In individuals who suffered from adiposity of the heart the various stages of the irregularity of the heart beginning with the simple intermittency up to the delirium cordis could be observed. Nothnagel looked upon the abnormal function of the central nerves or the fatty degeneration of the muscles of the heart as the cause for these appearances. In the case of intermittence of the pulsations the ganglia of the heart underwent changes which rendered their function impaired without the cardiac muscle becoming affected. Prof. Kisch was unable altogether to confirm the opinion of the French authors, viz., that the intermittence of the pulsations was a dangerous symptom, as he had observed such cases during twenty years. The complete arhythmia as well as the delirium cordis presented an unfavorable prognosis, for the reason that death was apt to occur suddenly.—*Med. Press*, May 15, 1889.

Evans (C. S.) on the Curative Effects of Erysipelas.—Among the diseases sometimes favorably affected or cured by erysipelas may be mentioned the following: Ulcers, polyarticular rheumatism, chronic insanity, syphilis (tertiary), favus, paralysis agitans, arthritis, various neuroses, syphilis (secondary), psoriasis trachoma, incontinence of urine, gonorrhœal orchitis, pleurisy with effusion, parotitis, dropsy, purulent synovitis, phthisis (*sic?*), carcinomas in various locations, sarcoma, lymphoma, and keloid. The theories of the healing in these cases, according to the author, are:

1. Paralysis of vessels. This theory rests upon the experiments of Donders, Snellen, and Weber. It might explain the healing of ulcers, etc., but hardly of constitutional diseases such as polyarthritis.

2. Through enlargement of the lymph-spaces and increased resorption (Hüter).

3. Tillman says that the tumor becomes so infiltrated with leucocytes that these not only undergo a fatty metamorphosis themselves, but cause the tissues to do the same.

4. Jaenecke and Neissler, who examined the carcinoma from their fatal case, report the streptococci as invading and filling the alveoli of the cancer.—*Cincinnati Lancet-Clinic*, June 8, 1889.

Burnett (E. C.) on Induration of Venereal Sores Not Always an Indication That Constitutional Syphilis Will Follow.—The author stated that there were sores that presented the aspect of the Hunterian chancres that were not followed by induration of the lesion, and also that certain indurated sores of venereal origin were not followed by signs of constitutional syphilis. In one case a physician had presented himself for examination with a typical indurated chancre situated in the sulcus coronarius. At first this lesion was only an excoriation, but it progressively increased in extent and depth. The patient had done nothing to the sore beyond keeping it clean. The lymphatic

glands in the left groin were hard and enlarged. The author prescribed simply lotions with a twenty-per-cent. solution of salicylic acid. At the end of three months the enlargement of the glands of the groin disappeared, but no signs of constitutional syphilis had yet made their appearance. The lesion had been observed sixteen months ago. Another physician had a suspicious intercourse which was duly followed by a typical lesion presenting the usual characteristics of an infecting chancre. After five months he showed no signs of syphilis, although no specific treatment had been used. Finger had attempted to explain the occurrence of such induration of non-syphilitic sores by invoking a peculiar arrangement of the blood-vessels of the region, or a local artificial irritation of the lesion. The author did not believe that induration took place by local irritation when the syphilitic virus was not present.—*N. Y. Med. Jour.*, June 8, 1889.

Testicle in the Perineum. — Mr. Lockwood reports an infant nine weeks old, whose left testicle lay in the perineum, the corresponding side of the scrotum being empty. The testicle seemed to be attached to the tuber ischii, and was accompanied by the processus vaginalis. Stress was laid upon this, because in these cases the process often communicated with the peritoneum, and in consequence operations for restoring the testicle to the scrotum had been fatal owing to peritonitis. Such cases seemed only moderately rare, and Mr. Lockwood has seen two others during the present year.—*Lancet*, June 8, 1889.

Fracture of the Thyroid and Cricoid Cartilages; Recovery.—An interesting and rare case was recently exhibited by Dr. Sokolovski at the Warsaw Medical Society of a woman in whom the anterior portion of the thyroid and both halves of the cricoid had been fractured through an accident with the strap of a mill. The immediate symptoms were severe pain in the throat, cough, and the expectoration of a considerable quantity of blood, also marked dyspnœa. Tracheotomy (inferior) was performed the second day. During the fourth week portions of the necrosed cartilage came away. After two months both halves of the thyroid were removed with forceps, and it was found that no trace of the cricoid remained, the posterior wall of the glottis being formed by the anterior mucous coat of the œsophagus. The patient made a good recovery, and was soon able to swallow food without difficulty. It is noteworthy that the condition of the larynx was accurately ascertained on the second day after the accident by means of the laryngoscope, and also that cases of fracture of the cricoid are almost invariably fatal. The author states that he has been unable to find more than one recorded case in which recovery took place after fracture of the cricoid—a case under the care of Freulich. He does not seem to have been aware of the case under Mr. Manby, of Wolverhampton (see *The Lancet*, Jan. 9, 1886).—*Lancet*, June 8, 1889.

Treatment of Stomach and Bowel by Compression in Cases of Catarrh and Dilatation.—Dr. Wettendorfer, of Vienna, has been devoting his attention to the application of this method of treatment, and furnishes a number of successful results achieved by the steady compression of the organ. He maintains that compression of a flaccid organ is the rational treatment. If the stomach be greatly dilated, the muscular power of the organ is reduced, and the presence of food will not induce contraction, neither will the secretions for the proper solution of the food be poured out in sufficient quantity to promote the assimilation of the ingesta. There is also another physiological fact that he considers is overlooked in the treatment of the stomach and bowels which he considers of great importance, namely, the widening of the blood-vessels of the skin and the stimulating of the nerves by the greater accumulation of blood, which increases the thermic conditions of the integuments and excites the reflex action of the sympathetic system. Professor Nothnagel has recently proved by his experiments that the outer coverings of the stomach and bowels play a very active part in the promotion of alimentation.

He assures us that anti-peristaltic action is nothing more than the effects of this external force, and that the contents of the bowel and stomach are forced in the direction of the least resistance. With this physiological fact in view, Wettendorfer is convinced by the number of cases experimented on both by himself and his colleagues, that this is the proper treatment. He cites a few cases in proof of this theory, where there was present a complicated condition of tenderness of the gastric region on pressure, dilatation of the organ,

catarrhal symptoms, and eczema—*trunci chronicum*. He treated the eczema with the usual orthodox remedies for that affection, but without success. Baffled in all his efforts, he discussed the scientific difficulty, and finally tried the "Martin-Binder" as a tentative remedy. The eczema disappeared like magic, and the other symptoms improved. He was surprised with his first efforts, and repeated the application, which proved equally satisfactory. The uneasy feeling about the stomach after taking a meal soon disappeared; sickness, eructations, and constipation of the bowels with any tenderness on pressure were speedily corrected by the use of the bandage a few hours every day. In cases of weight or oppression in the stomach after a meal, catarrh, dyspepsia, and a sluggish condition of the bowels, the elastic bandage when applied an hour after food will give undoubted relief. The Martin-Binder is an elastic bandage varying from eight to ten inches in breadth. There is one great advantage that will commend itself to the most sceptical, that whatever good we may derive from a trial of the remedy, we may rest satisfied that little harm will accrue, which cannot be said of all the remedies now in vogue for that frequently defaulting organ.—*Med. Press*, June 5, 1889.

Diller (T.) on Antifebrin in the Treatment of Epilepsy.—The author has tried antifebrin in nine cases of epilepsy, and concludes:

1. That in all the cases in which the drug was given continuously there was noted a reduction in the number of fits, ranging from about twenty-five to seventy-five per cent., as compared with other months during which patients were on bromide and tonic treatments alternately.

2. The remedy was in all cases well borne, producing no apparent mental or physical depression. This in marked contrast with depressant effects noted after a course of bromide treatment.

3. No skin eruption was produced.

4. In any given case, in which a great number of fits are occurring, and where it is desirable to control them as soon as possible, the bromides would be of far more value than anti-febrin.—*Therap. Gaz.*, June 15, 1889.

Woods (H.) on the Oxyiodides of Bismuth.—The red oxyiodide of bismuth (Bi O I) is an odorless, insoluble, fine powder, of a bright, copper-red color, and has very rapid healing properties. Acids decompose it, and the comparative ease with which it gives up iodine no doubt accounts for its powerful antiseptic influence. As an ointment (1 in 10) it is useful in some skin diseases, as well as for application to wounds and sores. The yellow oxyiodide of bismuth contains a very much smaller proportion of iodine, and is well adapted for application to mucous surfaces. It is a fine, insoluble, tasteless, and odorless yellow powder, with a decided antiseptic action. It is prepared by boiling subnitrate of bismuth in an aqueous solution of calx iodinata ($Ca O I_2$) in suitable proportions. Yellow oxyiodide of bismuth contains about 12½ grains of iodine to the ounce. It is decomposed by acids. It is a mild and healing application to wounds and sores, either in powder or as an ointment (1 in 10). I think the yellow oxyiodide will also be of use for internal administration in some of the cases in which the subnitrate is now given. It can be given internally in doses of 5 to 20 grains. The great advantage of the oxyiodides over other compounds of iodine consists in the fact that, while they are sufficiently stable for preservation, etc., they at the same time readily give up the iodine they contain.—*Br. Med. Jour.*, Apr. 6, 1889.

Stift (A.) on the Effect of Saccharin on Digestion.—The experimenter found that 98.68 per cent. of the saccharin taken is eliminated by the kidneys. Medium doses of saccharin produce a mild purgative action. With regard to the influence of saccharin on the digestion of food, he obtained by his experiments the following results. In the absence of saccharin, 69.17 per cent. of meat was digested, while by adding 0.1 gramme of saccharin 51.18 per cent., and with 0.2 gramme of saccharin only 43.09 per cent. was digested. The percentage of egg substances digested in a normal state—viz., 98.45 per cent.—was lowered by the addition of 0.1 and 0.2 gramme of saccharin to 96.69 and 88.68 per cent. respectively. Of caseine 98.78 per cent. was digested normally, but in the presence of 0.1 and 0.2 gramme of saccharin only 79.42 and 72.33 per cent. were digested. The same unfavorable results were obtained by experiments with starchy matters, thus showing the inhibitory action of saccharin on digestive fermentations.—*Lancet*, May 11, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON M.D.

With the active collaboration of

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OCCASIONAL REPORT ON DISEASES OF THE SKIN.

BY CONDICT W. CUTLER, M.D.

Martin (James) on a New Treatment for Acne.—The author has recently obtained very good results in the treatment of acne by using a vaporiser to which may be added the drug for external application.

This process of steaming the face is not only very beneficial to the complexion itself, but speedily removes impurities and black specks, such as are seen in acne comedones, and the redness of acne rosacea. Its action seems to assist the function of the pores, and to cleanse the skin of all impurities, acting in a similar manner as the Turkish bath. As soon as the stream is produced in the vaporiser it may be applied at about one foot and a half from the patient's face, and used for one half an hour.—*The Lancet*, May 11, 1889.

Fox (G. H.) on the Treatment of Acne without Arsenic or Sulphur Ointments or Lotions.—Dr. Fox divides acne for convenience into two forms, the irritable and indolent. The former admits of no other than the most soothing treatment, and is largely due to disorders of digestion or the sexual organs, and is chiefly benefited by diet and internal remedies. The indolent shows a coarse, doughy, greasy skin. The comedones and pus tubes should be evacuated and local treatment applied. Arsenic does not seem to act very well in other forms, and it is probable that patients would get along better if it were unknown. Ergot, however, possesses greater value than is usually given to it, especially in the indolent form of acne. The principles of treatment in both forms should be local massage and regulation of diet.—*Med. and Surg. Reporter*, May 11, 1889.

Bulkley (L. D.) on Psoriasis and Its Treatment.—Psoriasis rarely attacks the skin of the palms of the hands or the soles of the feet, and Dr. Bulkley has never seen it on the tongue, although it has formed over 43 per cent. of all cases of skin diseases which have come under his observation. The cause seems frequently due to change of temperature with much moisture. Between 10 and 15 years of age the female patients were double the number of males, while between 15 and 25 years of age the reverse was true. Over 40 per cent. occur before the second decade of life, and the youngest patient was a little over a year old. Over one third of all his patients had the disease for ten years or over. The longer the disease lasts, the less it is benefited by treatment. The disease is not self-limited. It is most curable in children, and less in patients between 20 and 25 years of age. Psoriasis is a constitutional disease and akin to rheumatism and gout. Meat eating increases its severity, and stimulants precipitate an attack. Oils and fats favor a cure, and wool should always be worn next the skin to avoid sudden changes of temperature, and patients should live in a warm climate. Arsenic, alkalies, and sulphur

water are the best medicines to use internally. Local applications are beneficial, especially if applied early, and the white precipitate ointment seems to act better than any other. He has given up the use of chrysophanic acid in private practice.—*Med. and Surg. Reporter*, May 11, 1889.

Menocal (R.) on Operative Treatment of Elephantiasis.—The patient was a young man who was suffering from a great enlargement of the left leg just above the ankle, which had begun to form about a year previously after an injury to the foot. There was no doubt as to the disease being elephantiasis. Tincture of iodine was given internally without result, and the following operation was decided upon under chloroform: A long incision was made the whole length of the anterior mass and carried completely through the skin, which was then carefully dissected back, exposing the hypertrophied mass of cellular tissue. This latter was then with considerable difficulty separated from its somewhat intimate connections with the adjacent muscular layer and removed *en masse*, the skin being then brought back into its proper position, the wound sutured and dressed with iodoform and boracic cotton, and the whole retained in its place by means of a compress bandage. The wound healed by first intention, and the dressings were taken off, with the exception of the bandage, on the tenth day. A month after the first operation, which was entirely satisfactory, a similar procedure was adopted with respect to the posterior mass, and this proved nearly as successful, the dressings being taken off on the fourteenth day. These were then replaced by an elastic bandage.—*The Lancet*, April 20, 1889.

Holgate (T. H.) on the Treatment of Nævus by the Intra-Injection of Alcohol.—The circulation to the nævus should be checked as much as possible by the pressure of a ring surrounding it before the injection is made, as it confines the alcohol and prevents it from being diffused for the time being farther than within its confines, and causes it to have a more powerful effect upon the fluids and tissues within its area; and the alcohol, by contracting the vessels beyond the nævus, more effectually prevents any coagula there from entering the general circulation. From five to seven minims of pure alcohol should be injected at one time into the tumor, and if the nævus is large more than one injection may be given at one sitting, or at short intervals of time, into different parts of it.

Two or three such injections usually result in a complete cure, only a slight stain or port-wine mark remaining. There are two precautions to be taken,—strict antisepsis, and care being used that no air is injected with the alcohol into the tumor. —*Archives of Pediatrics*, June, 1889.

Funk on the Therapeutics of Skin Sarcomata.—Dr. Funk (*British Journal of Dermatology*) states that arsenic, injected under the skin, has without doubt perfectly cured some cases of multiple idiopathic skin sarcomata, numerous cases of pseudo-leukæmia, and a few other new growths. In solitary skin sarcomata an early and perfect extirpation often shows good results; the section surfaces ought to be examined microscopically. There is no doubt that the operation, especially in melanosarcoma, may also have the worst consequences. In sarcomatous ulcerations iodoform ointment is of great benefit. Two cases of this last are reported cured by means of a 10 per cent. iodoform ointment.—*St. Louis Med. and Surg. Jour.*, June, 1889.

Buzzi (F.) on Thiol. — This agent possesses the reducing properties of ichthyol and resorcin, with the advantage of being very cheap. It has been successfully employed in the treatment of seborrhœa, rosacea, acne vulgaris, and eczema.

It is readily soluble in water, and used in the strength of 10 to 20 per cent. In a powder of the same strength it is a very useful application in vesicula troubles as zoster, dermatitis herpetiformis, impetigo, pemphigus, etc. It may also be used internally.—*St. Louis Med. and Surg. Jour.*, June, 1889.

Hutchinson on Arsenic Keratosis of the Skin and Arsenic Cancer. —A patient afflicted with cancer began taking arsenic in large doses. The skin, which had up to this time been perfectly healthy, became everywhere of a brown, earthy tint, and covered in part with scaly psoriatiform patches. This scaly condition of the skin was most marked upon the elbows and backs of the knuckles. The palms of the hands had become dry, slightly horny, and covered with little pits or depressions where the epidermis had broken down. In some spots the epider-

mal layers were thickened into small, hard corns.

The arsenic was at once discontinued and the pains in the stomach ceased, while the condition of the skin definitely improved. Upon resumption of arsenic, the skin became again affected in the same manner. The patient, who was affected with cancer before taking arsenic, did not develop any cancerous disease in connection with the "arsenic corns."

Another patient, after suffering from psoriasis for about twenty years, was attacked by epithelial disease of the hands, which occurred in regions previously occupied by horny growths for several years.

This case is well known to many physicians in Boston, and is fully described by Dr. White in an article entitled "Psoriasis, Verruca, Epithelioma, a Sequence," published in the *American Journal of Medical Sciences* for January, 1885. After making copious extracts from this article, Hutchinson says he has nothing to add to Dr. White's account, except to suggest that the verrucæ or "corns" which preceded the development of epithelioma in this case were themselves caused by the long-continued use of arsenic for the cure of psoriasis.

Another case was that of a patient who had taken arsenic for psoriasis for eighteen months. Corns developed on the palms of the hands and the soles of the feet, and an epithelial cancer on the scrotum.

Four other cases are reported by Mr. Hutchinson, who had taken arsenic for a long period and had subsequently developed corns and epithelial growths on portions of the body not usually the seat of psoriasis.

Mr. Hutchinson concludes by saying that the question to be considered is whether there be any real connection between the skin disease in these cases and the cancer following it, and if so, in what it consists. The reply suggested by the writer is that the bond of connection is to be found in the influence of arsenic given for the cure of the skin disease.

It seems highly improbable that psoriasis, however protracted, should in any number of cases result in cancer, and clinical experience does not support such a conclusion. The parts affected in the majority of these cases are precisely those which psoriasis does not attack. It is exceedingly rare for common psoriasis to show itself on the palmar surfaces, its favorite site being the extensor surfaces, and when the hand is involved it is generally the back. Yet in most of these cases which have been mentioned the palmar surfaces were affected, and keratoses, which are unknown as a part of common psoriasis, occurred late in the disease as a precursor of the cancerous process. The first case of all demonstrates the pernicious effect which arsenic may have upon the skin, and cases are often seen in which the integument has become dry, harsh, and muddy during the use of this drug, and occasionally instances occur where a great increase of cutaneous pigment is the result. It would appear that the influence of arsenic, when used to saturation during long periods of time, is to lower the nutrition of the skin and render it more susceptible to ordinary forms of irritation. Local pressure appears to cause the formation of corns upon the palms and soles in an unusual manner. The adjacent surfaces of the fingers also are affected in the same way. The writer considers that in all cases in which, during the use of arsenic for the treatment of any disease of the skin, the palms and soles become rough and corneous, this is an indication that the use of the drug should be stopped.—*Boston Med. and Surg. Jour.*, May 16, 1889.

OCCASIONAL REPORT ON DISEASES OF THE NERVOUS SYSTEM.

BY FREDERICK PETERSON, M.D.

Cook (A. H.) and Boulting (W.) on Injury by Lightning.—W. F., aged sixty-two, and D. H., aged forty-two, laborers, while at work in a wood, suddenly heard a thunder-clap. D. H. felt stunned for a few minutes, but had no sensation of pain, although his knife had been knocked out of his hand, his trousers were on fire, and the steel buckles were torn from his legs. He tried to walk, but fell down, and there was no feeling in his legs. His boots were in ribbons. He shouted for assistance, and could hear himself, though somewhat deaf. W. F. was senseless, and neither felt nor saw any thing of the accident. Insensibility was instantaneous. His clothes were torn off from him. A physician saw them one and one half hours later, and both were in a state of collapse,

and their features of a ghastly blue. W. F. was almost pulseless, but became slightly conscious on being roused. His whole right side had exactly the appearance of post-mortem staining, and in places was burned. He was well three days later, but so deaf as not to hear a watch laid against his ears or held between his teeth. D. H. was also burnt to a considerable extent in places, especially about the legs. His pulse was intermittent for several days. He recovered on the twenty-first day after the accident.—*Brit. Med. Jour.*, Aug. 4, 1888.

Thompson (G.) on Bromomania.—The author calls attention to the abuse of the bromides in the treatment of epilepsy in a paper on special hospitals for the insane (*Lancet*, May 11, 1889). Epileptics are drenched with bromides, especially in outpatient departments, until a form of bromomania, now well recognized in asylums, is established, and the epileptic, who fifty years ago passed easily through life, has to be put under restraint.

Flesch (M.) on a Case of Diphtheritic Paralysis.—A four-year-old child complained of toothache, and on examination of the mouth the author saw on both tonsils large round yellow patches, which he called diphtheritic, although there was no fever, redness, swelling, or albuminuria, and the child felt in general very well. Twelve days after, the patches had disappeared, and eight days later appeared paralysis of the palatal muscles and a transient paralysis of some of the ocular muscles.

This was therefore a case in which every objective symptom of diphtheria was wanting, and the nature of the disorder was only discovered by accident. It was purely local, and yet led to a nervous disease, which showed the presence of a strong infection in the organism. The child recovered.—*Centralb. für klin. Med.*, May 25, 1889.

Suzuki (S. M.) on the Tendon Reflexes in Leprosy.—While examining a case of anæsthetic leprosy the author was surprised to find the knee-jerk increased. Afterward he took note of this in other cases. Some were affected with leprous tubercle all over the body in an advanced stage; others had a few scattered anæsthetic patches or showed atrophy of the interossei and enlargement of the ulnar nerve, without marked anæsthesia or turbercle. The tendon reflex was exaggerated in five such cases that he had examined.

The nervous symptoms of leprosy are attributed to multiple neuritis, indicated by muscular wasting and anæsthesia, greatest in degree toward the extremities of the limbs, and unpleasant tingling sensations. The neuritis of leprosy is typically interstitial; the primary sheaths and secondary sheaths of the fasciculi are greatly increased in thickness by nucleated fibrous tissue, arranged concentrically.

Authorities hold at present that from whatever cause multiple neuritis may arise, the tendon reflex is invariably abolished, even in the early stages of the disorder. It is often seen to be lost entirely in kak'ke and diphtheritic and alcoholic paralysis.

He had observed altogether 17 cases in his hospital and private practice in Tokio. In 12 the reflexes were increased, in one present, and in four there was even ankle clonus. He naturally asks then why the tendon reflex is increased in the neuritis of leprosy. Is the pathology of leprous neuritis truly known? If so, how explain the exaggerated reflexes? Does leprosy cause such changes as lateral sclerosis or disseminated sclerosis? He then points out that whereas in the neuritis of kak'ke, diphtheria and alcohol, paralytic symptoms are always prominent, in leprosy it is of very rare occurrence, even in advanced cases. This is frequently observed in leper asylums, where in advanced stage muscular strength is well preserved. This maintenance of muscular power and increase of tendon reflex are too contradictory to admit of explanation as merely multiple neuritis.—*Sei-i-Kwai Med. Jour.*, May, 1889.

Calcification of Brain Membranes.—Dr. Osler has presented at the Philadelphia Pathological Society a specimen of calcification of the dura mater from an elderly women. The dura was not specially adherent, but a large portion covering the left hemisphere was a uniform plate of calcified tissue. On the right side there were irregular areas of lime deposits. The same condition existed on each side of the longitudinal sinus. There was general senile atrophy of the viscera, but no great deposit of lime-salts in the blood-vessels (*Univ. Med. Mag.*, Dec., 1888). Dr. Sneve has reported a case of calcified falx cerebri in the *Med. News* of March 23, 1889. Dr. W. R. Jackson reports another more inter-

esting in the *Med. News* of April 13, 1889. This case was a negro, aged forty, who died of syphilitic disease of the pia mater. The anterior two thirds of the falx was calcified, the plate resembling a scythe-blade, about 4 inches long, 1 inch wide, and varying from ¼ to ½ inch in thickness. Death was not supposed to be due to the calcified falx.

Suspension in Locomotor Ataxia.—At the last meeting of the Berlin Society for Diseases of the Mind and Nerves, Professor Bernhardt reported his recent experiences of the "suspension method" in the treatment of dorsal tabes. Professor Bernhardt has tried it with nineteen patients, some of whom were suspended by him more than twenty, others from fifteen to twenty, times. They almost always stood the treatment well. The impression which this new method made on the minds of the patients was evidently very favorable, and, though this circumstance must be taken into account in judging of the results, indisputable improvements were observed in the majority of cases. Some of the patients, indeed, declared that they were not conscious of any good effect; but Professor Bernhardt observed, as have Charcot and others, that most of them could walk better, and were decidedly improved in general condition. — Berlin corr. *Lancet*, June 8, 1889.

Rienzi (E. de) on Loss of Knee-Jerk in Onanism.—This author states that if in weak and pale children, whose condition cannot be explained by any discoverable organic disorder, and whose very excitable and sensitive vascular system would lead us to suspect rather increased than diminished reflexes, complete loss of knee-jerk is found, then we have an indisputable sign of masturbation. This fact is suggested by the numerous cases which have come under his observation.—*Revista clin. e terap.*, 1888, No. 7; *Centralbl. für klin. Med.*, April 20, 1889.

Jones (E. L.) on the Treatment of Headaches.—In acute headaches, with low vascular pressure, such as toxic headaches from alcohol and tobacco, exercise and food are potent remedies, and relief is obtained from cardiac stimulants, such as:

℞	Spir. ammon. aromat. . . .	ʒ ss.
	Spir. chloroformi	♏ x.
	Aquam ad.	℥ i.

Antipyrin in gr. iii. doses, repeated if necessary, is also useful. In chronic headaches of this character where there is anæmia iron is necessary; but as iron alone may cause headache, it is best to give ♏ i.–♏ iii. of tr. digitalis with it. If there is no anæmia the digitalis alone will be found efficacious.

In acute high-pressure headaches, the bowels must be kept open. Nitrite of amyl carefully administered in very dilute state is useful; but still more useful is nitro-glycerine. In anæmic girls, the last is particularly useful, given in doses of $\frac{1}{100}$ of a minim twice daily. Mix one minim of a one-per-cent. solution of the drug with water in a six-ounce bottle and give two tablespoonfuls as a dose. More than six doses should not be ordered.

In recurrent high-pressure headaches alkalies are most beneficial, and when anæmia co-exists iron is also indicated. It is best to give the iron with an alkaline carbonate as follows:

℞	Sodii bicarb.	gr. x.
	Ferri et ammon. cit.	gr. v.
	Spiriti chloroformi	♏ x.
	Aquam menth. viridis ad. . .	℥ i.

M. *Fiat haustus, ter die ante . . . s semihora sumendus.*

In persons of uric-acid diathesis a mixture of 20 grains citrate potash with 10 of salicylate of soda is useful.

Nitrite of amyl is useful in many cases of neuralgia of the scalp, where the patient's phraseology is, "when I comb my hair, I can't bear it."—*Practitioner*, May, 1889.

PATHOLOGY.

Meredith (J.) on the Relation of Hemorrhages to Unhealthy Surroundings.—On September 22, 1888, a little girl, aged nine, was brought to me owing to severe attacks of epistaxis, which had been going on for three days. The child looked ill. I examined her, found her tonsils enlarged, and she had some mucous matter sticking about in the fauces. The glands on the side of the neck were hard and swollen. I was well acquainted with the little patient and her family. I very soon came to the conclusion that the illness was due to what, with your permission, I will call "malsany."[1]

In a couple of days the mother reported

[1] This is the word which the author proposes to introduce to express insanitary surrounding conditions.

that the bleeding was not stopped ; that it came on while she was in bed as well as when she was up sitting by the fire. She had given up playing, only she walked out towards the other end of the row of houses in which she lived, did not care for her food, but was always drinking.

A few doors off from her mother's house, in the same row, is a pump, placed at the side of a garden plot, and which is still used by many of the occupants of those houses. Soakage from garden plots was apt to find its way into the well. The water was very hard, of course, but the people all liked the taste of it.

I asked my little patient, at the second visit, if she went to the old pump for water, and she replied : " Yes, often ; like it better than the tap water." I told her to discontinue this practice at once, and on no account to drink any water except that taken from the tap. As soon as this was done the bleeding from the nose ceased, and the child rapidly recovered in other respects.

A few years ago I had a very severe case of epistaxis, in the house next to that where the child just mentioned lives ; it happened to a man, aged seventy, and it lasted a great many days. Astringent injections and all the recognized applications gave very imperfect results. He partook of the water, and that freely, from the pump just referred to.

The old man was exposed to another malsanic influence at the same time, and that in his own dwelling. Under the stairs, in his cellar, he had a quantity of turnips stored, and some potatoes as well. The slow decay and drying smell from these penetrated his house, and was powerful about the door of his bedroom. His friends cleaned out the cellar and the bleeding soon ceased and he remained in good health since.

In a corner of the parish in which I live is an isolated block of houses. The block is surrounded by highly cultivated garden plots. On the north side, between the houses and cultivation, is the well. The subsoil is sandy and porous. Some time ago the water in the well was evidently impure and not safe to drink, and the state of things around the well's mouth was not sanitarily satisfactory. During the period nearly all the women in the place suffered from excessive discharge at their monthly periods, amounting in some to severe menorrhagia. After the insanitary matters were removed, by properly securing the well and reconstructing the drains, the females of the tenement improved in health, and the menses resumed their ordinary character, not, however, without leaving permanent marks on the constitution of more than one among them.

At times cases of menorrhagia are met with which run on for a period of about three weeks. It may be that an apparent stopping appears at the end of the first week, but the relief is very short, for on comes the flow ; a similar illusionary occurrence may be witnessed at the end of the second week, only, however, to end in disappointment. At the end of the third week there is a cessation, and the patient feels disencumbered from a sense of lassitude at the same time. The instances where I witnessed this peculiarity were in women who were exposed to sewer-gas and sewage polluted water. But sewer-gas and sewage-polluted water are often the causes of typhoid fever, and the ordinary duration of an attack of typhoid fever in this district is three weeks. Perhaps the greatest number of these cases of excessive catamenia last for about a week or ten days. I have been satisfied, in all cases of this character, that I have inquired into, that they were the victims of some unhealthy influences or other, usually polluted water, or drain air, or both.

Now there is a febrile condition, perfectly well known, which runs a course of about a week or ten days, and is the result of blood-poisoning from noxious air or some other matter. For example, I had two cases of illness in the same house ; one was typhoid fever, which ran its ordinary course, and the other one of high febrile character, lacking many of the peculiarities of true typhoid ; in it the temperature of the body returned to normal on the ninth day, in the other on the twenty-second. That certain things in chemistry take nine days to nitrify, while others take less, is in this connection only an additional fact, suggestive of thought and, of course, further inquiry.

All the serious cases of bleeding hæmorrhoids I have had to deal with have been cases of persons living in unhealthy dwellings. I am, of course, aware that in all such cases there is a more or less disordered condition of the liver and digestive organs ; but there is just as good reason for ascribing the disordered state of the

liver to piles as piles to disordered liver. As a matter of fact, in very many instances, they are both only features of the one complaint, dependent on some form of malsany.

I have noted what seemed to me good cases of hæmaturia resulting from protracted imbibition of noxious air and impure water, which, when the offending elements were removed, began to improve, and ultimately recovered. The bleeding in scurvy, purpura, and some other disorders as well, are all of a similar nature, and only too familiar. The common saying that any spontaneous or passive hemorrhage is only an effort of nature to right itself may be very true, but what is the cause of the wrong that has to be righted? And then, what is the wrong itself? It strikes me we must pay closer attention than ever to what has aptly been said to account for the progress of modern engineering, and that is to "the next to nothings" in investigating the causes of diseases.—*Br. Med. Jour.*, Feb. 16, 1889.

Cornet on the Channel of Tuberculous Infection.—The knowledge that infection in cases of pulmonary phthisis took place generally through particles of dried sputum reaching the lungs was important from a prophylactic point of view as the speaker pointed out, and if we could determine the point of entry of the virus in glandular tubercle also, our aim would be more intelligent and precise. The speaker's attention was first directed to the cervical submaxillary and occipital regions. He showed some guinea-pigs into whose conjunctival sac some sputum containing tubercle bacilli had been placed. No injury of the sac took place. Notwithstanding this, the bacilli grew, penetrated the tissues, and set up swelling and hyperplasia of the conjunctiva. In all the animals caseation and softening subsequently took place in the neighboring glands. The side on which the inoculation took place showed the most extensive changes. In two other animals the nasal mucous membrane was painted by means of a pigeon's feather, with bacillary sputum in one case and a pure cultivation of tubercle bacilli in the other. The corresponding glands became tuberculous in both cases. In other cases the cavity of the mouth was inoculated with sputum or pure cultivation material, and all the corresponding glands became tuberculous. In another guinea-pig infective material was introduced into the ear, and the auricular glands became subsequently caseous. In still another animal the skin over the nose was shaved clean and sputum rubbed in, when later on a serpiginous ulceration covered with a thick scab reminding one of lupus, was observed; the cervical glands became much enlarged. Another animal was scratched on both cheeks with a finger-nail dipped into tuberculous sputum, and the ulceration, covered with scab, that followed, spread and became confluent. Another animal was rubbed, but without abrading the surface, with a wash leather that had been dipped into bacillary sputum; after some weeks it was killed, when the corresponding lymph-glands were found enlarged. Other animals again were infected from the vagina, penis, toes, etc. He concluded that tubercle bacilli could penetrate into the system without causing distinguishable injury at the point of entry. The nearest lying glands became tuberculous, and illness developed resembling scrofula as it was often seen, and without doubt scrofula depended on a tuberculous infection from without. This was the less remarkable when we remembered how incautiously we treated phthisical sputum, and how frequently children made a way for the entrance of disease, by putting every possible object within their reach covered with tuberculous dust it might be, into their mouths, up their noses, or into their ears. —*Med. Press*, June 12, 1889.

McNish (J.) on a Peculiar Case in Which Glycosuria Complicated a Severe Burn.—A blacksmith, aged fifty-six, a total abstainer, and whose previous and family histories are good, was severely burned on September 3d, through the ignition of a bottle of kerosene. On examination, burns of the second and third degrees were found afflicting the whole of the right hand and forearm up to the elbow joint. The left hand, forearm, and half the upper arm were severely burned, and at intervals over the surface were large yellowish-white eschars. Considerable tracts of skin had been removed from the wrists and lower parts of forearms, through the patient rolling in grass for purpose of extinguishing the flames. Large blisters were found on the left side of the abdomen, and on the anterior surface of the left thigh. Shock was inconsiderable; temperature, 98°; pulse, 70. Considerable pain and thirst were complained of. The wounds were

treated in the usual way, and dressed with carron oil, while absolute rest and a nourishing diet were ordered.

Sept. 9th.—Temperature normal; pulse, 76; appetite good; very slight thirst; bowels regular. The eschars had separated, and the wounds presented a healthy appearance, commencing cicatrization being visible at the edges. Little or no pain was experienced except when the dressings were being removed. Dry iodoform was now dusted over the wounds, and over this oiled lint was applied. The dressings were ordered to be changed daily.

Sept. 10th.—Patient expresses himself as feeling well; temperature, 99°; pulse, 74, good; appetite and digestion good; specific gravity of urine, 1023; no albumen or sugar; slight deposit of pink urates; wounds look exceedingly well; very slight inoffensive discharge, and cicatrization progressing rapidly.

Sept. 16th. — To-day, although the wounds look well and healing has advanced since last visit, a marked diminution in the strength is noticeable, with considerable emaciation. Temperature, 102.8°; pulse, 100, soft and feeble. Intense thirst and frequent desire to micturate were complained of, with an increase in the quantity of urine, 2½ quarts having been passed during preceding twenty-four hours. On examination the urine was found to have sp. gr. 1032, and gave distinct saccharine reaction with Trommer and Fehling's tests. An anti-diabetic diet was ordered, and 1 gr. of codeia three times a day.

Sept. 20th.—Wounds still progressing favorably. Temperature, 103°; pulse, 120; patient greatly prostrated and slightly delirious, but would answer questions sensibly when spoken to firmly. Sp. gr. of urine, 1043; strong saccharine reaction; about four quarts passed in twenty-four hours.

The symptoms continued much the same as on last date until Sept. 25th, when the thermometer registered 104.2°. The wounds looked well, with the exception that a small abscess formed in the subcutaneous cellular tissue on the anterior surface of the injured thigh. This was poulticed, and discharged the following day, leaving a healthy-looking sore.

Oct. 3d.—Wounds almost wholly healed; temperature, 102°; pulse, 126, very feeble and intermittent; low muttering delirium, with every appearance of approaching coma. The urine on examination gave almost the same results as on last visit. Emaciation and prostration extreme; patient would eat or drink any thing put to his mouth, but had no expressed desire for either food or drink.

Oct. 5th.—A marked change for the better took place. Temperature fell to 100°. Reason returned, and thirst diminished, as did also the amount of urine; sp. gr. 1022, with only traces of sugar.

Oct. 8th.—Temperature, 98.8°; pulse, 86; urine, sp. gr. 1023. Patient expressed himself as feeling stronger, with good appetite and no abnormal thirst.

Continued improvement took place until October 11th, when the patient was able to walk out. His urine showed no trace of sugar with the ordinary tests, and he was pronounced convalescent. A perfect recovery took place, and he is now engaged daily at his usual avocation.—*Australasian Med. Gaz.*, April, 1889.

Cancer of the Breast.—The history of 194 cases of cancer of the breast treated in Professor Gussenbauer's wards at Prague has furnished Dr. Fink with some interesting statistics. He found that at the forty-first year the frequency of cancer suddenly increased, slowly rising towards the age of sixty; 128 of the cases occurred between forty and sixty, 38 between sixty and eighty, and 28 between twenty and forty. Activity of the sexual functions had a marked etiological influence, especially in regard to long periods of activity of the functions of the mammary gland; 72.1 per cent. of all the cases had borne children (38 patients bearing 6 or more children) and 62.8 per cent. had suckled them. In only 12.7 per cent. could a reliable history of injury or prolonged mechanical irritation be obtained, and heredity was only open to suspicion in 8 out of the 194 cases. There seemed to be no tangible liability to the disease on the part of one breast more than the other. In 153 of the cases the breast was amputated and the axilla cleared of infected glands. The mortality was 3.3 per cent., but 90 of the cases subsequently had recurrence of the disease, owing, in many cases, to their having postponed applying for treatment until an advanced period of the disease. 21.6 per cent. remained free from the disease for two years, and 16 per cent. for three. The average prolongation of life in the operated, as compared with the others, was seven months.—*Med. Press*, June 12, 1889.

Elliot (J. W.) on a Peanut Shell Lodged in the Bronchus.—A powerful young man drew into his throat half a peanut shell on the evening of June 2, 1888. He had at once a fit of coughing lasting half an hour. On admission to the hospital he breathed without trouble, but had occasional attacks of coughing, followed by a continuous whistling noise, lasting half a minute, which could be plainly heard in all parts of the room.

Examination showed the respiratory movements of left side of chest deficient, and the respiratory murmur entirely absent. It was therefore evident that the peanut had entered the left bronchus.

Thinking that nothing could be gained by delay I immediately opened the trachea as low down as possible. Violent coughing was excited by tickling the trachea, but the peanut could not be dislodged. Long forceps were repeatedly passed down into the trachea and into both bronchi, but no foreign body could be felt. The difficulties seemed insurmountable in that the very large size of the patient made the working distance exceptionally long and the lightness of the peanut shell made an almost intangible object. The patient was held upside down and the same procedure again failed. Respiration was then found to have returned in the upper lobe of the left lung, so it seemed as if the object had been pushed further down. A large tracheotomy tube was placed in the wound and the patient sent to the ward.

The night after the operation was a quiet one. Patient did not cough much, and breathed easily all through the day. Examination of the chest showed that the respiration had returned throughout the left chest, but was absent (or nearly so) over the lower lobe of the right lung. This showed that the peanut had been coughed out of the left brochus and had lodged in the right.

At the consultation of the surgical staff it was decided to make no further attempt to extract the peanut shell, but to wait, hoping that it would be coughed out. The tracheotomy tube was removed three days after the operation without difficulty. The larynx was examined by Dr. F. H. Hooper, who found nothing abnormal beyond an inflamed condition of the lining membrane of the trachea. The patient said that he felt first-rate, and was up and dressed on the two following days. On the next day, however, six days after the accident, he developed a cough with profuse mucopurulent expectoration. There was no dulness, and a few râles could be heard over both sides of the chest, and increased voice sounds over a small patch in the lower right axillary region.

During the next week the patient grew steadily worse; the expectoration became more profuse and very foul. The temperature fluctuated between 102° and 103°. The pulse rose steadily to 150, and the respiration to 40. Bronchial râles were heard and felt in abundance over the entire chest. The chest was repeatedly examined by Drs. Fitz, Langmaid, Cutler, and others, and at one time it was thought that an abscess had formed in the lung which could be opened and drained. But even this last hope was finally abandoned, and the patient died on the seventeenth day.

The autopsy made by Dr. Fitz showed that the right bronchus, at the level of its second branch, was plugged by one half of a peanut shell broken off across the constricted middle portion of the nut. There was putrid bronchitis with gangrenous pneumonia; acute pleuritis of the left side; atelectasis, etc.—*Boston Med. and Surg. Jour.*, June 20, 1889.

Bond (A. K.) on Aneurism of the Abdominal Aorta, Bursting into Pleural Cavity; a Mass of Tissue Plugs the Opening; Patient Rallies, and Dies Two Hours Later.—A colored day-laborer, æt. 35, was admitted into hospital for supposed chronic rheumatism. He was not confined to bed, but walked about the ward with a cane, stooping in walking, because he he was unable to straighten his left leg at the knee. He had pain in the course of the left sciatic nerve, and for a few days in the left inguinal region. There was constant pain on the right side in the lumbar and gluteal regions. He complained at one time of coldness in the lower limbs. His pains were worse in cloudy weather, and often more severe at night. The attending physician, without careful examination, diagnosed rheumatism, and treated him with liniment, and with mercury and iodide of potassium, with considerable relief to the pains. On the morning of the fourth day after this diagnosis, the patient was bright and cheerful, but did not rise and dress as usual. At 12.30 o'clock, he was helped to the commode, and, just as he was sitting

down upon it, he fell over upon the floor, unconscious. He was lifted to the bed and recovered consciousness. Being summoned immediately, I found him greatly agitated, with rapid respiration, tumultuous heart, and scarcely perceptible pulse. He kept his hand over his heart, and said it pained him very much. I gave him a small dose of carbonate of ammonia and whiskey, and he soon seemed so much better that I left him, ordering a turpentine stupe over the region of the heart, and directing the attendant to call me if he became worse. About two hours later the patient died, before I could be summoned.

On post-mortem examination I found the left pleural cavity filled with blood and dark blood-clots, the left lung being contracted to a very small bulk. Through a round opening 1½ inches in diameter, in the posterior left quarter of the diaphragm, projected a rough mass of tissue, which plugged up the opening. On section, the lungs were healthy. The heart and pericardium were normal. The peritoneal cavity was free from blood. The intestines lay more in the right than in the left half of the abdominal cavity, the fossa to the right of the spinal column being filled by a retro-peritoneal mass, which pushed forward the kidney, and appeared to be continuous with the mass which projected through the diaphragm. The left kidney was normal, the spleen somewhat anæmic, the bowels normal. There was no sign of disease in the parts to the right of the spinal column. Cutting off the aorta close to the diaphragm, I turned it downward, and found that, at the upper margin of the eleventh dorsal vertebra, it opened to the left into a large aneurismal sac which formed the mass before mentioned. The aorta left the sac again about two inches below the cœliac axis. The cavity of the aneurism was filled with blood-clots and granular debris. There were masses of laminated deposit adhering to its walls. The 11th and 12th vertebræ were on their left sides bare and much eroded. The spinal canal was not open, but its bony wall was very much thinned from pressure of the aneurism. The 11th and 12th ribs on the left side were eaten quite through at 1½ inches from their articulation with the vertebræ. The wall of the aneurism was of varying thickness, according to the nature of the surrounding structures. The aneurism extended upward along the left psoas muscle to the diaphragm, through which it opened into the left pleural cavity; and downward along the psoas muscle and to the outer side of the great blood-vessels as far as Poupart's ligament. At the upper part the cavity of the sac was large enough to admit the hand; at the lower part it became gradually smaller. The mass which filled the hole in the diaphragm was a part of the wall of the aneurism.—*Maryland Med. Jour.*, June 22, 1889.

Sisley (R.) on a Case of Aneurism of the Ascending Part of the Arch of the Aorta; Rupture into the Superior Vena Cava.—The patient was thirty-five years of age. It was not ascertained whether he had had syphilis, but he had a scar on the dorsum of his penis. One night in January, 1888, as he was about to go to bed, he suddenly reeled and fell down in a state of insensibility, but he immediately regained consciousness. He had no similar attack at any other time. During the winter of 1888–89 he had a cough, but did not complain of shortness of breath. His wife noticed that when he returned home from work his eyelids were puffy and his face rather swollen. This condition was only seen at night; by the morning the œdema had always disappeared. On March 14th the patient left home as usual, and it chanced that his work lay in front of St. George's Hospital. Not feeling well, he went in for advice; but he did not consider himself seriously ill, and wished to go home. His face and neck were deeply cyanosed, his eyelids puffy, and his ears almost black. His arms were slightly cyanosed. The other parts of his body were of natural color. A double murmur was heard over the middle of his sternum. His mental state was clear, but he was drowsy. He complained of no pain, and had no paralysis.

Dr. Ewart diagnosed that the man had an aortic aneurism, which pressed on his vena cava superior. The patient was bled to sixteen ounces. It was noticed that his cephalic and jugular veins pulsated, and that the man bled very freely. There was, indeed, a difficulty in stopping the hæmorrhage; an ordinary bandage did not suffice, and a splint was applied. The patient was not relieved by venesection. His face and arms became gradually more cyanosed, and he became more and more drowsy, and finally comatose. He died about two hours after his admission to the hospital.

At the necropsy it was found that the right side of his heart was healthy. The left ventricle was slightly hypertrophied. The aortic valves were not thickened. The aorta was atheromatous. There were no patches of calcification. In several places there were depressions measuring about a quarter of an inch in diameter. The depressed parts were puckered, and the aortic wall was thinner there than it was elsewhere. It was evident that the depressions were caused by cicatricial contraction following endoarteritis. Three quarters of an inch above the posterior aortic valve there was a saccular aneurism. The opening into the aorta was of rounded form, and an inch and a quarter in diameter. Beyond the opening the sac measured about an inch and a half in its transverse diameter and two inches from above downwards. The wall of the aneurism was smooth, except where it was in contact with the walls of the vena cava and of the right auricle. The aneurism extended between the walls of the aorta and the right ventricle as far downwards as the interventricular septum, and upwards to a point three quarters of an inch below the opening of the innominate artery. About the centre of the right posterior part of the aneurism there was an opening into the vena cava immediately above the entrance of that vessel into the right auricle. The opening was of irregular form; its edges were ragged and thin, and they projected slightly into the vena cava. The aneurismal sac contained a small clot. It was not adherent to the walls of the sac, nor was it laminated.—*Lancet*, June 15, 1889.

THERAPEUTICS.

Jackson (S. K.) on the Carbon Compounds; Their True Place in the Treatment of Fever.—The author emphasizes the necessity of a diagnosis between malarial and typhoid fever; which is important on account of their different characters and their different treatment. It is only the carbon compounds that are particularly efficacious in malarial fevers; as the nitrogen compounds are demanded and are eminently efficacious in enteric fever. Dr. Barnett's suggestion of the use of salicylate of ammonium is particularly valuable for that hybrid form of fever to which Dr. Woodward gave the name of "typho-malarial," and not in pure typhoid fever. The carbon compounds generally are only indicated, and could only be expected to be useful in those forms of fever which are due to a *fermentative* process caused by organisms exhaling carbonic acid, since they are chiefly destructive of this class of organisms, and have little or no toxic effect upon those causing fevers which are accompanied by processes analogous to putrefaction, in which ammonia or sulphuretted hydrogen are evolved—*e.g.*, typhus, typhoid, and the septicæmic fevers.

These theoretical views exactly correspond with, and are confirmed by, clinical experience, as no agents have been found so efficacious in malarial fever as the carbon compounds—none more potent in typhoid fever than the ammonium salts; and more probably, more valuable in septic fevers than salts of sulphurous acid. This clinical experience justifies a reliance upon the use of these excretory products, viz.: carbonic acid, ammonia, and sulphuretted hydrogen, as agents for the destruction of the several organisms producing them, as being nature's mode of inhibiting their life-processes in accordance with the law, that no organism can live in its own excreta—that is, in the products of its life-processes.—*Med. Register.*, Dec. 8, 1888.

McKinnon on Venesection in Puerperal Eclampsia.—The author warns the younger members of the profession against placing any confidence in bromide of potassium, or even chloral, in this critical condition. The inhalation of chloroform he considers a very valuable remedy or adjuvant, but would not rely on hypodermatics of morphine. He is inclined to believe that venesection saved more lives in puerperal eclampsia than all other remedies. In puerperal eclampsia he believes the patient dies from brain pressure, due to serous infusion, hemorrhage, or œdematous infiltration, and that venesection is the most effective method of preventing this brain pressure. Bleed the patient to the extent of a pint or more. As an evidence of this intra-cranial pressure during a convulsion, Dr. McKinnon refers to the occurrence of sub-conjunctival and retinal hemorrhages, which he has frequently seen. He does not advocate

venesection as a measure to arrest the convulsion, but by diminishing the tension on the cerebral vessels to disarm the convulsion of its fatal power.

He gives the following guide to treatment when called to a case of puerperal eclampsia:

1. Bleed the patient, if convulsions be severe or followed by coma.

2. Control the convulsion with chloroform.

3. If patient be at full time, take steps to terminate labor as quickly as possible.

4. Administer an active purgative: Epsom or Rochelle salts.

5. If the convulsions recur, give a large hypodermatic of morphia.

He reports seven cases of puerperal eclampsia occurring in his own practice; they all recovered, venesection being employed in six of these cases.—*Canadian Practitioner*, June 17, 1889.

Chromic Acid in Sweating of the Feet.—The Prussian army have recently commenced the use of chromic acid, varying from five to ten per cent. solution, to be applied to the soles of the feet every three or four weeks. If there be any broken surface, the solution must not exceed five per cent. till it heals, after which the solution may be increased to ten. If the sweating be of a moderate character the application must not be made oftener than every six or eight weeks, but if very intense it has to be applied every fortnight for the first months. In the height of summer the whole body may be similarly treated, but two applications are considered sufficient to relieve the most obstinate cases, and it is said to leave no bad effects. This assertion must, however, be received with a certain amount of caution, as a death following its use caused the order from head-quarters to be modified, though it has been assumed that the death was caused by the use of an impure solution. The first order was sent out on the 9th of July, 1888, and this modification, on the 30th November of the same year. Since then its use was limited to the five-per-cent. solution in all cases till they proved obstinate. We are now in possession of an authoritative report on this tentative remedy, which refers to those who suffered in the summer and autumn months from July to September, and the period of recruiting from November to January, 1889. Beside this division of time, the report sub-divides the cases into three degrees of severity. 1. A severe form in which the skin of the foot is constantly wet, red, and swollen, particularly between the toes, the foot tumid and macerated, in which cases the sweat rapidly decomposes and produces an intolerable stench. 2. A middle class is given, of cases in which the sweating is confined to the sole of the foot, which also produces dampness and fœtor. The third class comprises cases due to much walking on very hot days. The solution must not be applied by means of brushes made with metal holders, as the chromic acid is apt to decompose the latter, and on this accouut wood is to be preferred. Again, if bathing the feet be allowed, it must be done in an earthenware utensil for the same reason; but the brush is by far the best means of applying the solution. The action of the chromic acid hardens animal tissues by withdrawing the fluid matter and coagulating the albuminous constituents. The ten-per-cent. solution has a metallic, corrosive taste, and produces a dry, yellow, contracted appearance of the skin, and it can be observed to have entered the sweat ducts, but when this altered epithelium is thrown off, the sweating again commences to exude freely. By there petition of the ten-per-cent. lotion the tissues can be mummified and eroded, bringing about a condition similar to that which often occurs to workers in certain industries. The ulcers produced by this substance assume a peculiar cylindrical shape, but they sometimes take the form of an eczema. There were upwards of 18,000 soldiers treated by chromic acid during the six months over which the report extends, and the result of the experiment is decidedly favorable. Of these 18,000 patients 42 per cent. were cured, 50 per cent. improved, and 8 per cent. unaffected.

The cheapness of the drug seems to be one of the principal reasons for preferring it to salicylic acid. It may be noted also that of the number treated in the army by this method, only 25 cases can be said to have exhibited any symptoms of chromic-acid poisoning, and this number includes cases in which chromic acid had been applied to reduce swelling and enlargement from other causes. All seemed to bear the application of the solution without much discomfort beyond a slight prickling, burning, or tickling sensation over the part.—*Med. Press*, June 12, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON DISEASES OF CHILDREN.

Prudden (T. Mitchell) on the Etiology of Diphtheria. — The author wishes to record a series of operations made, in the light of modern science and with improved technical facilities, on a number of cases of diphtheria occurring in and near New York The cases thus fully studied were those in which the clinical history left no room for doubt as to the diagnosis. The autopsies were in most cases made by Dr. William P. Northrup, a competent and experienced observer.

The writer studied in detail, both by morphological and biological methods, twenty-four cases of diphtheria in young children, most of them occurring in hospitals, in which the affection assumed the character of an epidemic, the disease either occurring by itself or in connection with suppurative diseases, or scarlatina, or measles. In all but two of these twenty-four cases, there was demonstrated the presence of a streptococcus, usually in large numbers in the local lesions, and in small numbers, in a few of the cases, in the viscera.

The specific character of this streptococcus was established by the biological methods employed; and by animal inoculations in rabbits and pigeons it was found that it was markedly pathogenic, inducing erysipelatous or phlegmonous inflammation, abscess, and localized necrosis. Efforts were unsuccessful to induce on the mucous membrane of animals any lesions which could be fairly regarded as similar to the local lesions of diphtheria, as ordinarily developed in man. The author thinks that diphtheria, as it is seen in man, does not apparently occur spontaneously in animals, and has not been induced experimentally by any of the numerous and variously modified inoculations thus far practised.

In control examinations of mouth- and tonsil-scrapings from thirty-one healthy and sick children, not apparently exposed to diphtheria, the streptococcus was never found, except in two cases of scarlatina, in which diphtheria soon after developed. On the other hand, in examining throat- and tonsil-scrapings from forty children exposed to the disease in a hospital in which it was epidemic, in twelve of them, the streptococcus was found. Once it was found floating in the dust of the room in which the disease had originated. All of these observations, taken together, seem to lead to so strong a presumption that the streptococcus is the causative factor of diphtheria, in this set of cases, at least, that to the author it practically amounts to a demonstration. Reason was found for believing on biological and experimental grounds that the streptococcus occurring so constantly in these cases of diphtheria is probably identical with the streptococcus pyogenes and streptococcus erysipelatos. It has been shown that the apparent identity of the inciting species of bacteria in erysipelas, in some forms of phlegmonous inflammation, and in at least certain groups of cases of diphtheria, is not only not inconsistent with our knowledge

of the pathology and symptoms of these three forms of inflammation, but serves to account for various facts concerning the nature and spread of diphtheria which have hitherto seemed obscure.

It was found that the crypts of the tonsils form a favorite nesting-place for the streptococcus, and that it may lie harmlessly there even in considerable numbers, unless some lesion of the mucous membrane provides conditions suitable for its growth, when it may enter upon a career of active proliferation.

In the presence of the streptococcus in large numbers in the local lesions of diphtheria and in its absence in any considerable number, as a rule, in the internal organs, there is ground for the belief that the symptoms of systemic infection are probably in large measure due to the absorption of a soluble poison produced by the bacteria at the seat of their most active proliferation.

It was demonstrated that the streptococcus of diphtheria is not readily destroyed by drying, but both in the form of pure cultures on threads and fabrics, and in the pseudo-membrane itself, may retain its vitality for long periods when dried in the air. Its vulnerability, when brought in contact with some of the commonly used antiseptic agents, was tested, and it was found, first, that the vapor of burning sulphur is very inefficient and unreliable in destroying the germs. Carbolic acid and creolin, in considerable strength, destroyed the streptococci, but in dilute solutions were inefficient. Corrosive sublimate, even in very dilute solutions, heads the list in its killing power. But all these germicides are much less efficient when applied to the bacteria which lie embedded in the pseudo-membranes and the tissues, than when they are free in the pure cultures.

Having thus presented some definite knowledge about the germ which appears to be capable of inducing diphtheria, the author applies this knowledge to measures for the prophylaxis and treatment of the disease. For the details of house disinfection, the author formulates a set of directions. Every thing that can be wet is to be soaked or scrubbed in a 2 per cent. solution of carbolic acid. Polished furniture should be rubbed with a dry cloth. All clothing which cannot be washed, as well as beds and bedding, should be sent to the public disinfecting station to be steamed. If the walls are papered or frescoed, and cannot be scrubbed, they should be rubbed down with lumps of bread, the crumbs to fall on the wet carbolized floor. The room should be exposed to the air for at least twenty-four hours.

In the light of these experimental studies, the importance of local antiseptic methods becomes confirmed, and further research rather tends to give precision to the ends to be attained by them, than to suggest any thing new.—*Am. Jour. Med. Sci.*, April and May, 1889.

Baruch (S.) on Nocturnal Enuresis.—The author, who has had an extensive experience with this disorder at the New York Juvenile Asylum, advocates the use of atropine, instead of belladonna, and urges the necessity of bringing the system completely under its influence. Dr. Baruch orders a sufficient quantity of atropia in the afternoon at four, and at bedtime, seven, to insure dilatation of the pupil; $\frac{1}{64}$ of a grain for children from six to ten, and double the quantity for children up to fourteen, administered at these hours, usually suffices. If the pupils are widely dilated when the next dose is due, it is omitted. The essential point to be clearly impressed upon the parent or attendant is that the pupil must be dilated during the sleeping hours, as an indication that the system is under the influence of atropia. The results with this method of using an old remedy have been very satisfactory in the practice of the author.—*Arch. of Ped.*, April, 1889.

Prudden (T. M.) and Northrup (W. P.) on the Etiology of Pneumonia, Complicating Diphtheria in Children.—Dr. Northrup has shown, by statistics from the New York Foundling Asylum and from foreign sources, how frequent and important are lobular and broncho-pneumonia as complications of diphtheria. The lungs of seventeen children, dead of diphtheria complicated with pneumonia, were examined morphologically and by cultures. In all the cases but one, the lungs contained a streptococcus similar to that of the pseudo-membrane of the throat. There were found no other species of bacteria in these lungs with such frequency and abundance as to justify the belief that it stood in a causative relation to the inflammation. The authors were able to induce in rabbits, with the greatest uniformity, by the intratracheal injection of

pure cultures of the streptococcus isolated from the children's lungs, a lobular and broncho-pneumonia very similar in its character to that which they had in the children. It was found that the injected bacteria do not, as a rule, gain access, at least in demonstrable numbers, to the blood and the other viscera of the animals. From the observations it appeared that after inciting the local inflammatory process in the lungs of the animals, the bacteria rapidly disappear.

The authors arrived finally at the conclusion that the acute lobular and broncho-pneumonia which is apt to complicate diphtheria in the upper air-passages in children, is, at any rate in the set of cases which they examined, a form of inspiration pneumonia, induced by the streptococcus diphtheriæ, which finds access to the lungs from the foci of diphtheritic inflammation in the air-passages above.—*Am. Jour. Med. Sci.*, April, 1889.

Cheadle (W. B.) on the Various Manifestations of the Rheumatic State as Exemplified in Childhood and Early Life.—Acute rheumatism, as essentially characterized by articular inflammation, is based upon observation of the disease as seen in adults. In the rheumatism of early life, however, other morbid conditions appear prominently and constantly, which may claim equally with the arthritis to be regarded as direct results of rheumatic activity, and in childhood arthritis cannot be regarded as alone typical, essential, and representative. The presentation of rheumatism in childhood should be regarded as representative, and the changes which take place in the phenomena with advancing age should be regarded as modifications of the earlier and more perfect form. Manifestations of rheumatism which are common to children and adults are endocarditis, pericarditis, pleurisy, and tonsillitis. Other phases of the disease, rarely seen except in early life, are subcutaneous tendinous nodules, chorea, and exudative erythema. The author treats of these seven phases (excluding many doubtful ones) as the Rheumatic Series.

In early life the articular affection has not yet become the chief feature of rheumatism, but is usually slight, and may be absent altogether from a seizure undoubtedly rheumatic in its nature, while other phases rule as prominent and characteristic features. The joint tissues are less susceptible, the other fibrous tissus more so. Subcutaneous nodules, so frequent and significant in early life, practically disappear with the advent of puberty; and chorea, so common in childhood, disappears as maturity approaches. Endocarditis and pericarditis, though frequent in adult life, are still more so in childhood. In early life arthritis is at its minimum; endocarditis, pericarditis, chorea, and subcutaneous nodules at their maximum. In adult life the reverse is the case.

Another point of distinction between the rheumatism of childhood and that of later life is the tendency of the various phases to arise independently and apart from each other.

The rheumatic series as seen in children may, indeed, be complete or incomplete in any degree. The whole series may follow in succession, or may be limited to a single event.

The author finds rheumatism somewhat more common in males than in females. The statistics of the Collective Investigation Committee of the British Medical Association yield in 655 cases 375 males to 279 females. But up to the age of twenty there is a preponderance of females. Beween eleven and fifteen, females are in great preponderance. A strong confirmation of this special susceptibility of young girls to rheumatic arthritis is afforded by the fact that the rule holds with regard to scarlatinal rheumatism.

The author believes in the influence of family predisposition, and that rheumatism is transmitted as strongly as the tendency to gout. The inherited tendency has been variously estimated at from 25 to 35 per cent.

The author takes up in detailed description the various phases of rheumatism, arthritis, endocarditis and pericarditis, anæmia, tonsillitis, erythema exudativum, erythema nodosum, purpura rheumatica, chorea, subcutaneous tendinous nodules.

In considering the treatment of rheumatism the writer lays great stress upon the fact that almost the whole interest and importance of rheumatism in children centres in the cardiac inflammation and its results. The one great point is to constantly guard against an insidious attack of endocarditis or pericarditis. When there is suspicion of rheumatic inflammation—even if no cardiac affection be perceptible—absolute rest in bed should be enjoined upon the patient.

Large doses of salicylate of soda are rarely to be used in rheumatism of children. Salicin may be given in place of salicylate of soda in most articular cases with advantage, as being less depressant. Alkalies are strongly advised as an additional measure, to be given with the salicin.—Harveian Lectures, *Lancet*, April 27, May 4 and 11, 1889.

Sturgis (R.) on Recurrent Headache in Children and its Treatment.—Children not infrequently are troubled with headache, more or less severe, recurring at intervals of days or weeks. The child usually has suffered from headache for a year or more before treatment is sought. As a rule, these patients are of nervous temperament, do not sleep well, grind their teeth at night, and frequently suffer from bad dreams and nocturnal terrors. Sometimes such children will have a spasmodic cough. The headaches, as a rule, come on in the morning. The pain is generally localized in some particular part of the head, frontal region, either side, or at the vertex, rarely occipital. The pain is usually severe enough to prevent work or play. There may be optical illusion of sparks or spots and bands of color. The picture is that of migraine in adults, except that the pain is rarely unilateral. It is rare that there is nausea and vomiting. The possible connection with chorea has been suggested, but cannot be proven. The fact of heredity, the author has established in several cases.

During the last six years, the writer has seen some twenty cases of recurrent headache. Not meeting with success in the treatment of these headaches by the general heads, the author remembered the "fanciful hypothesis" of Drs. Bois-Reymond and Möllendorf, that the pain may be due to excitement of the terminal sensory filaments of the fifth pair by dilatation of the capillary blood-vessels of the dura mater. Ergot was administered for its effect on the arterioles, and the result was satisfactory. The author's custom is, to satisfy himself that the headache is not due to gastric or intestinal disorder, to disease of the kidneys, heart, brain, or lungs; that it is not due to excessive use of tea or coffee, and that it cannot be accounted for by astigmatism or other abnormality of vision. If none of these causes exist, ten minims of fluid extract of ergot are administered, generally alone, sometimes with iron. The ergot should be continued at least two weeks after the disappearance of the headache.—*Arch. of Pediatrics*, May, 1889.

E. S. B.

OCCASIONAL REPORT ON FRACTURES AND DISLOCATIONS.

BY CHARLES A. POWERS, M.D.

Moore (E. M.) on Epiphyseal Fracture of the Humerus.—The author, after describing in detail a number of cases which had fallen under his observation, makes the following resumé:

1st. The symptoms of this fracture are striking and uniform. The shaft of the humerus is so inclined as to carry the elbow a little backward and outward, while the superior end of the shaft is brought forward, so as to make a prominence less rounded than the head and lower down. This is usually found about an inch and a half below the acromion (the distance varying a little with the size of the youth) and near the coracoid process. The curved line from the acromion down to this projection has a long sweep, instead of the small sphere of the natural head. This appearance is pathognomonic, and may be safely trusted in diagnosis without insisting upon crepitus. As in other epiphyseal fractures, this is not clear and sharp as when the fracture is of bone, but is muffled. When the arm is moved gently, and without grasping the head, the peculiar lock of the surfaces is sufficient to cause the head to rotate, and thus the timid practitioner fails in getting his pathognomonic sign—but if the head be firmly grasped, it cannot only be felt in the glenoid cavity, but be held sufficiently firm to get this muffled crepitus by rotating the humerus, or by carrying the elbow inward and thus rubbing the two surfaces on each other. In addition to these striking symptoms, we may add the fact of a shortening of half an inch or a little more in the length of the humerus. When the two shoulders are inspected from behind, the impression produced on the mind of the surgeon is that described as subluxation, for there is a slight flattening of the shoulder. The breadth of the shoulder is also increased when seen in profile. The motions of the arms are somewhat circumscribed. The ability to carry it upward and forward, as well as upward and outward,

is impossible much beyond a right angle with the body.

2d. The reduction of the fracture is effected by carrying the arm forward and upward to the perpendicular line.

3d. The retention is effected by moderate extension, while bringing the arm down to the side, maintaining the slight extension until dressings for the purpose of continuing it are applied. Swinburne's method fulfils the indication easily and perfectly.

4th. Even if not restored, the arm soon becomes useful, and nature gradually rounds off the prominence of the diaphysis, and elongates the capsules at the lower border, allowing the motions upwards to improve.—*Buffalo Med. and Surg. Jour.*, March, 1889.

Wharton (H. R.) on Diastasis at the Upper End of the Humerus.—The patient was a girl of seven years who fell down-stairs, sustaining an injury to the right shoulder. There was disability at the joint, a prominence in front of and to the inner side of the acromion, the head of the humerus was in the glenoid cavity and failed to move when the shaft was moved. Soft crepitus was elicited. A simple confining dressing was applied, and a speedy and complete recovery ensued.—*University Med. Jour.*, Jan'y, 1889.

Weir (R. F.) on Fracture through the Head of the Fibula, Caused by Muscular Contraction and Implicating the External Popliteal Nerve.—The patient was a gentleman, aged twenty-one, who had fallen while wrestling with a companion. His left leg, he stated, was twisted around that of his antagonist. As he fell he felt something give way, and found that he was unable to walk. His leg was carried decidedly to the inside of the thigh, so that the entire limb was bowed outward. The joint was greatly distended with blood, but no fracture of the femur nor of the tibia was made out. Just above the joint, however, on the outer aspect of the external hamstring tendon, was felt a hard mass of the size of the end of the thumb, movable in several directions, and apparently bony in character. Below this point was a depression, at the lower end of which, about one inch from the bony mass felt above, was the squared-off end of the fibula to be felt. This bone, on being measured from the external malleolus to this fractured edge, was found to be nearly an inch shorter than the bone of the uninjured leg. Diagnosis was made of a tearing off of the upper portion of the fibula by the action of the biceps muscle. The limb was placed on a well-padded Volkmann's splint, and cotton placed over the joint.

It was, on the following day, found that there was a loss of sensation commencing about the middle of the outer aspect of the leg and running downward and extending over the central portion of the dorsal aspect of the foot from the ankle to the toes. In this latter region the sensibility was utterly lost. The patient was, moreover, unable to turn his foot outward or to draw up the ankle, showing that the peroneal and anterior groups of muscles had likewise been deprived of their innervation. The patient's condition was very satisfactory, and no inflammatory reaction had shown itself in the joint.

A brief review of reports of cases brought plainly into view the fact that the paralysis was due, as has been proved by a post-mortem section, to a division of the external popliteal nerve just above its division into the musculo-cutaneous and anterior tibial nerve. The question therefore arose whether the permanent disability that resulted in most of the cases that had recovered from the lesion to the bone could not be averted in this case by a surgical operation, having for its end the exposure and suturing together of the divided ends of the nerves.

This being affirmatively decided, on the tenth day after the injury the patient was etherized, and, under antiseptic precautions, a curved incision some six inches in length, the centre of which corresponded to the gap between the fractured bones, was made alongside of and down to the posterior edge of the tendon of the biceps muscle. On exposing this, the external popliteal nerve was recognized and traced downward to the separated capitulum of the fibula, and was subsequently dissected out from that point downward for nearly an inch below the lower end of the fractured fibula, where it divided in several branches. The trunk of the nerve was found not to be divided, but bearing just below the separated piece of the fibula marks of contusion, such as swelling and ecchymosis, and a moderate constriction, as if some of the fibres had been crushed in. The nerve was still attached to the small fragment, and below this point it was apparently stretched by the action of the biceps. It was therefore carefully separated from the loose piece of

bone and freed in this way from the further effect of tension. The depth of the nerve injury was not ascertained. The fracture itself, when brought clearly into view, proved to be not as large as it was supposed through the skin, and consisted simply of the styloid process of the fibula torn off and drawn up about an inch and a half. The surface of the body of the fibula was smooth, and it was evident that the fracture had occurred at the epiphyseal junction. The lateral and posterior parts of the joint were seen to be open, but great care was taken not to disturb the clots which partly closed this rent. Two drainage-tubes, one running down to the joint and one anterior to it, were placed in the wound, the edges of which were closed and antiseptic dressings applied. The limb was again placed in the Volkmann splints.

Nothing special need be said regarding the progress of the case. No reaction occurred; the wound healed with two dressings in ten days, the tubes being removed when the first dressing was changed.

It was not considered practicable, from the small size of the detached fragment, to undertake, at the time of the operation, the wiring of the two fragments of bone together, nor was any attempt made, by permanently and strongly flexing the limb, to approximate them.

The patient made an excellent recovery, and, three months later, walked long distances with but a slight limp.—*N. Y. Med. Jour.*, May 26, 1888.

Pratt (J. Dallas) on Lateral Luxation of the Ungual Phalanx of the Thumb.—The patient, a man forty years of age, slipped on the street, and putting out his hand to save himself, came down on the point of the thumb. The two bones were lying side by side and the dislocation was complete. It was reduced by bending the phalanx to a right angle with the one above it, and then making downward traction in the axis of the latter. The lesion is one of great rarity.—*Dublin Journal Med. Sci.*, June, 1889.

Cates (B. Bradson) on Subspinous Luxation of the Humerus.—A woman, 58 years of age, was thrown from a carriage, striking on the right elbow and shoulder. The shoulder was swollen, contused, and tender. Movements of the arm elicited great pain. There was a firm, unyielding, round tumor beneath the spine of the scapula. This moved when the humerus was rotated, and the head of the bone could not be felt in the axilla.

Reduction was effected by extension and counter-extension with pressure from behind.

[Undoubtedly a subspinous dislocation, though these are so rare that all evidences should be carefully noted, the direction which the axis of the humerus presents, measurements, etc.—C. A. P]

Stewart (Nolan) on Simple Dislocation of the Carpal Scaphoid.—The patient, a man twenty-four years old, was thrown from his carriage, striking on his left wrist. There was a hard tumor on the dorsal aspect of the wrist at its outer side, and Dr. Stewart says that he could define(?) the outline of a scaphoid bone in this tumor. The hand was strongly drawn downward and adducted, when pressure on the luxated bone forced it into place.—*Med. Rec.*, Oct. 6, 1888.

Wight (J. S.) on Dislocation of the Carpus.—Six cases are cited, all backward, and each occurring in a boy under fourteen years of age. In two there was an accompanying diastasis at the lower end of the radius. All presented the usual evidences of the posterior projection of the carpal bones with the anterior projection of the radius, and all were easily reduced by traction and counter-traction with forward pressure on the wrist and backward pressure at the lower end of the radius.

[The reader is referred to page 620, of the ANALECTIC for Dec. 24, 1888, for notes on the value of a hitherto undescribed tubercle at the posterior aspect of the lower end of the radius in the diagnosis of fractures and dislocations about the wrist.—C. A.P.]

Battle (Wm. H.) on Backward Dislocation of a Proximal Phalanx.—Notes are made of six cases which fell under the author's care. In two cases the thumb was the seat of the lesion, in two the index, and in one each the middle and little fingers.

In two cases reduction was effected in the ordinary way by hyperextension and downward traction, in three subcutaneous tenotomy was performed, and in one the joint was exposed and the glenoid [1] ligament withdrawn from between the articular surfaces.

[1] In two cases which recently came under my notice all attempts at reduction were unavailing; the joint was exposed, and the glenoid ligament found to lie between the ends of the bones.—C. A. P.

After a thorough resumé of the literature of the subject, the author lays renewed stress on the now accepted theory that the glenoid ligament, by its displacement between the articular surfaces, prevents replacement. He recapitulates the methods of treatment recommended, in the order in which they should be tried: 1—Manipulation by the "dorsi-flexion" method, without violence, and without (or on failure with) anæsthetic. 2—Subcutaneous section of the glenoid ligament from the back of the joint. 3—In the case of the thumb, subcutaneous division of one or both heads of the flexor brevis muscle. 4—Incision into joint under antiseptic precautions, with replacement of ligament or the long flexor tendon. 5—Excision of the head of the metacarpal bone after severe compound fracture or ankylosis of joint (especially of the thumb).

Mayo (C. W. Robson) on New Method of Extra-Articular Suture of the Patella.—The method, which is extremely simple, consists in passing a steel pin through the aponeurosis immediately above the upper fragment, then one through the aponeurosis immediately below the lower fragment—that is, through the upper part of the ligamentum patellæ. The two fragments are then easily drawn into apposition by a ligature over the pins on either side, "not by a figure of 8 ligature over the patella." The extra portions of the projecting ends of the pins are cut off by wire-nippers, a layer of antiseptic gauze is placed over the projecting pins and ligatures, and a pad of antiseptic wool bandaged over the whole, the limb being then placed on a back splint. The dressings are not disturbed for a month, when the pins are removed and a plaster-of-paris bandage is applied to keep the knee from bending for a little time longer.

If there be much effusion of blood in the knee, the joint is aspirated before the fragments are brought together. The pins are asepticized before being used.—*British Med. Jour.*, March 30, 1889.

Stimson (L. A.) on a Case of Forward Dislocation at the Lower End of the Ulna.—The patient sought treatment at the Chambers Street Hospital, May 14, 1888, immediately after having received an injury of the right wrist. In the sudden descent of a dumb-waiter the hand and wrist had been caught between the upper edge of the inclosure and the lower surface of one of the shelves of the waiter. There was a slight abrasion on the radial aspect of the lower two inches of the forearm, and a contusion immediately opposite on the ulnar aspect, extending an inch higher. The hand was in complete supination, and could not be pronated. The normal prominence of the ulna at the back and side of the wrist was lost, and on palpation the ulnar border of the lower end of the radius and the portion of the upper posterior border of the carpus corresponding to the ulna could be distinctly traced. The relations of the carpus to the radius and metacarpus were unchanged. On passing the finger from the fifth metacarpal upward along the dorsum and ulnar side of the carpus, a bony lump (presumably the unciform) could be felt, and then a narrow, transversely elongated bone, which was thought to be the cuneiform. Above the latter was a deep depression, in front of which, on the front of the wrist, the lower end of the ulna could be felt. The triangular fibro-cartilage could not be recognized.

Reduction was easily made, with a distinct snap, by forced pronation combined with pressure backward upon the ulna and forward upon the radius. The dislocation could be easily reproduced by supinating the wrist and pressing the ulna forward.—*N. Y. Med. Jour.*, May 25, 1889.

Van Arsdale (W. W.) on Subluxation of the Head of the Radius.—The author, in an extremely able and exhaustive article, presents statistics of 100 cases occurring in his own practice, and concludes as follows:

1. The injury frequently occurring in children and called subluxation of the head, or displacement by elongation, of the radius is a well-defined, typical injury, with well-marked, constant symptoms, and due to the same anatomical lesion in each case.

2. The frequency is over one per cent. of surgical injuries in children.

3. It occurs in children under nine years of age.

4. The most frequent exciting cause is sudden traction by the hand or fore-arm; more rarely a fall.

5. The principal symptoms of the injury are: absence of appreciable deformity; loss of function of the arm; localized

pain over the head of the radius on pressure ; pronation of the hand ; slight flexion of the elbow. Crepitation or snapping upon forced supination with restoration of function.

6. Treatment with a splint is advisable in order to prevent recurrence.

7. The anatomical lesion causing the injury is not yet satisfactorily established. —*Annals of Surgery*, June, 1889.

Thomson (G. S.) on a Ready and Effectual Method of Applying the Principles of Manipulation in the Reduction of Recent Dislocations of the Shoulder-Joint.—The patient—suppose the right humerus is dislocated—(subcoracoid) is placed on the floor on his left side, and the surgeon stoops or kneels beside him, and, taking the patient's right arm, places it with the forearm lying over the operator's neck, whilst the patient is directed to grasp the wrist of the injured arm with his left hand, or lock his fingers together. The surgeon is thus hugged by the arms of the patient. Now, in order to effect reduction, traction should be made " in the axis of the bone perpendicular to the glenoid fossa," as this allows relaxing of the muscles (the main obstacles to reduction), and is the best method of overcoming the mechanical difficulties preventing reduction. By gently raising himself into a more erect position, the surgeon makes traction on the extremity in a gradual, continuous, steady pull, and the weight of the patient's body acts as the counter-extending force, whilst the right hand of the operator, placed in the axilla, feels the head of the bone, and with a gentle touch of his fingers the bone slips into its place. Both hands help the mind to change the direction of the traction into the line of least resistance by the swaying motion the surgeon can impart to his body in the "hunkering" position in which he acts.—*British Med. Jour.*, Feb. 16, 1889.

["Hunkering" is an excellent term to apply to all such crude and unscientific methods for the reduction of subcoracoid luxations. Space is given to this description simply because it affords us an opportunity to strongly advise that it should never be employed. "Kocher's method" should be used in all subcoracoid dislocations. It has been noted in a recent issue of this journal, and is described in full in the *Medical Record* for March 30, 1889. —C. A. P.]

THERAPEUTICS.

On the Relief of Tympanites by Puncture of the Abdomen.—Two additional successes of this apparently harmless remedy have been recently reported.

The first is by Mr. W. L' H. Blenkarne. *Br. Med. Jour.*, March 9, 1889.

The patient was an old man with cancer of the rectum, which was so dense that not even flatus could be ejected. The distension of the abdomen was most distressing, and to alleviate this we punctured the abdomen on several occasions, the transverse colon being the part chosen. Immediate relief was affected for the time being, and there were untoward results, the punctures healing up without the slightest inflammation or suppuration, of course the man eventually died, but his expressions of gratitude for what was done certainly inspired me to resort to the same treatment in any similar case. The trocar I used was the small one generally attached to caustic cases, and the operation was performed every other day for some fortnight or so.

The second case was reported by Dr. J. Jenkyns, *Br. Med. Jour.*, April 27, 1889 :

"The patient was a male, about forty, and became the subject of tympanites from obstruction of the bowels, due to a collection of hardened fæces at the ileo-cæcal valve. The usual remedies were employed, but with little or no success in evacuating the bowels, and Dr. Mair suggested tapping the large intestine, in order to relieve the urgent symptoms caused by the distension of the abdomen. This was done, the part selected being the ascending colon, about an inch and a half above the seat of obstruction. Almost immediate relief followed, and in a few hours a large evacuation of the bowels occurred. The same operation was repeated in a day or two on the opposite side (descending colon), and with correspondingly good results, the bowels continuing to act every alternate day until death supervened from exhaustion (all the urgent symptoms having disappeared after the gaseous accumulation was removed by the tapping), the patient having come from the country, where he had suffered for some time before coming under my care.

The trocar employed was similar to the one used by M. Blenkarne.

Safety of Apomorphia as an Emetic.—Mr. John Brown, in the *Br. Med. Journal*, March 9, 1889, believes in the entire safety of the drug, and reports ten instances of its efficacious and harmless employment. He says:

"The average interval between the hypodermic injection and the emesis is 10.1 minutes. As a rule, the vomiting only occurs two or three times at short intervals. The depression is only what might be expected after an ordinary vomiting. I have observed no case approaching fatal or even serious collapse. Only two of my cases were adults, the others were very young children. Two were my own children, and I have the greatest confidence in giving it hypodermatically to any of my children who may require an emetic. Every one must have observed how difficult it is to make an infant or any child under four years of age vomit by giving emetics by the mouth."

Dr. Talfourd Jones, *Br. Med. Jour.*, Feb. 9, 1889, champions the safety of the drug in moderate doses, but expresses it as his opinion that the doses as given by most writers are too large, and advises $\frac{1}{15}$ to $\frac{1}{10}$ grain as an average dose to give hypodermatically to an adult of average body-weight.

Dr. Lewis Hickey has had two unpleasant experiences with the drug, *Br. Med Jour.*, Feb. 9, 1889.

An infant, aged three weeks, suffering from acute bronchitis. The case had gone from bad to worse, and death seemed imminent from dyspnœa, the cough failing to expel the secretion. Emetics of ipecacuanha and sulphate of zinc having no effect, one fortieth of a grain of apomorphine was given hypodermatically, almost as a last recourse. After about three minutes, the child became pale, and retched, but failed to vomit; this was followed immmediately by marked symptoms of collapse, increased pallor, and very feeble respiration; artificial respiration was performed, and the lips were moistened with brandy, and soon these alarming symptoms passed off, the child eventually recovering.

The second case, that of a woman, aged thirty-four, was also one of acute bronchitis, but was complicated by asthma and slight dilatation of the heart; the asthma was congenital. The patient was ill for three days before she sent for advice, and on the third day of my attendance, her condition was the most serious, chiefly from the extreme dyspnœa. Emetics of sulphate of zinc, and mustard and water, failed to act, and one fifteenth of a grain of apomorphine was injected beneath the skin. After a very short interval the patient, who was sitting up in bed, fell backwards, the pulse, which was fairly good before the injection, was now hardly perceptible, and respiration was most feeble. Brandy was with difficulty given by the mouth, and artificial respiration was performed, with the result that after some fifteen minutes, the patient was restored to much the same condition as she was in before the injection. In this case no retching or vomiting was produced, and the patient said she had no feeling of nausea. After two or three hours the heart began to fail, and death ensued some five hours after the injection, but was, I think, in no way hastened by the treatment.

In both cases the apomorphine used was the preparation in tablet form.

Willoughby (E. F.) on Pilocarpine in Threatening Mania.—A man, naturally a sound sleeper, had for several weeks been almost unable to sleep, and during short dozes talked of business. His appetite had failed, and for the three or four days before I saw him, though he had gone as usual to his office, he had scarcely slept or eaten. I found him in bed in a darkened room, with wet cloths on his head, singing, shouting, gesticulating, snapping his fingers, talking wildly and seeing illusions. His temperature was at least 104° F. (I could not keep the thermometer anywhere for more than a minute on account of his restlessness), his skin (as it had been, I was told, for several days) dry and burning, and his throat and mouth parched, with viscid mucus, which he tried vainly to hawk up. I may add that he had not resorted to alcohol, being almost an abstainer. My first thought was to obtain sleep as the only means of averting mania, and I gave him twenty-five grains of chloral hydrate, fifteen minims of liq. opii. sed., and a glass of milk. Six hours later I saw him again; he had not closed his eyes, and was talking incessantly and more incoherently than before. I then determined to try pilocarpine, and injected one-sixth of a grain in the arm at 10 P. M. Not more than five minutes had elapsed before profuse perspiration and salivation commenced. Next morning at 10 A. M., I found him

perfectly calm and rational, his skin cool and moist, temperature in the mouth 99°, his head clear, and appetite returning. He had had seven or eight hours of refreshing sleep, and gave a most graphic description of the flow of perspiration and saliva, which had been, he said, such as he could not have believed had he been told it by any one else. He felt well, though weak, but not more so than he was before the crisis.—*Lancet*, May 25, 1889.

Hay (C. M.) a Clinical Study of Paraldehyde and Sulphonal.—The practical deductions that the author's experience with these two drugs would suggest are :

1. That paraldehyde is the safer hypnotic where a continuous action is desired.

2. That paraldehyde has a wider range of application in mental disease than sulphonal, and that in the insomnia of acute or chronic disease, where pain, cough, dyspnœa, or fever exist, sulphonal is less effectual than paraldehyde.

3. That in all depressed mental states sulphonal acts ineffectively, and acute melancholia should be a contra-indication to its use, while in maniacal conditions it is more satisfactory than paraldehyde. That the use of the former in general paralysis of the insane should be carefully considered, while in acute melancholia the latter is usually effective.

4. That a high degree of physical debility with insomnia should contra-indicate sulphonal.

5. That in 18 per cent. of cases various degrees of sulphonal intoxication appear, and that it would seem that the drug is capable of being dangerous to life, and that, therefore, the commencing doses should be small, some persons being extremely sensitive to its influence.

6. That the effects produced by sulphonal are not always in proportion to the dose administered, and that in some cases at least it very seriously interferes with the normal bodily secretions, while paraldehyde does so to a very much less extent.—*Am. Jour., Med. Sci.*, July, 1889.

Strock (D.) on the Use of Quinia in Labor.—For several years past I have been using less and less ergot ; and during the past year I can say that in these cases where I have given it, it was due to the reason that I did not have quinia at hand.

It is my custom, when called to a case of labor, to first examine if there are any reasons why strong contractions would not be desirable. If I find the presentation favorable, and the uterus acting feebly, or not as vigorously as desired, I then give the quinia. But if the uterus is doing all that can reasonably be expected of it I do not think it advisable to give any medicine. When quinia is indicated, it is best to give it in generous doses. Let the first dose be ten or fifteen grains, and if, after reasonable waiting, there is no responsive action in the uterus, give five or ten grains more. But you will not often have occasion to repeat the dose. The length of time it takes to obtain the effects of the medicine varies between fifteen and thirty minutes, depending, of course, upon its absorption by the stomach.

The woman will become more cheerful, even though she is in greater pain ; she will assist herself with increased energy ; if you examine, you will find the os dilating more rapidly or the head advancing, as it were, with vigorous strides ; and a case that gave promise of being tedious and prolonged will be terminated in a comparatively short time under the influence of this article.

In primipara, I think it is good practice to give a dose of quinine early in labor, as you will thereby materially shorten the process without endangering the mother or child.

In any case of breech presentation, or in a transverse presentation, after turning, I think the chances of delivering a living child will be greatly increased if quinia is given ; of course, in a transverse presentation the drug is not admissible until after podalic version has been practised.

Moderate rigidity of the os is not a contra-indication to the use of quinia. In fact, I think the drug is indicated, because the increased power of the contractions impels the head against the os with such force as to induce dilatation, and there being an absence of the specific action upon the circular fibres of the cervix that characterizes ergot, there is not increased resistance coincident with increased contraction.

By the use of quinia we can obtain firmer and more constant post-partum contractions, thus lessening the possibility of hemorrhage, modifying the severity of the after-pains, and accelerating the process of involution.

I have used quinia very freely in all stages of pregnancy, but have never known it to do harm. It does not originate contractions, and, therefore, can be given to a

pregnant woman without causing her to abort. But given in labor, or in miscarriage when the contractions are not powerful enough to expel the ovum, and in such cases when the placenta is retained, I have always found it efficient. In abortions occurring early in pregnancy its action is not so rapid as in premature labor or labor at full term.

I have never known a puerperal patient to complain of any unpleasant symptoms as the result of the exhibition of what are ordinarily considered large doses of quinia. —*Med. Register*, April 6, 1889.

Morison (A.) on Somnolence with Cyanosis Cured by Massage.—The patient was a man of forty-three, who, when young, had contracted syphilis. Suffered for at least fifteen years from drowsiness, and during the last two years became deeply somnolent. He would fall asleep while interested in and playing a game of cards, the cards suddenly dropping out of his hands on to the table, and he beginning to snore, and his face becoming darkly engorged until his companions succeeded in rousing him. On one occasion he fell asleep while standing on a door-step waiting for the door to be opened, to the imminent peril of his neck, but for the aid of a bystander. From this state he was roused after a snorting and choking sound had issued from his respiratory passages, the cyanosis then gradually disappearing. He has been treated for about two years almost without result by antisyphilitics, antilithatics, a limited nitrogenous dietary, the injunction of exercise, and abstinence from or great moderation in the use of alcohol and tobacco ; a diet necessary to a free liver, and the son of a free liver, who had eaten, drunk, and smoked, without any knowledge of or regard for consequences. Other physicians prescribed quinine and Epsom salts. Neither had any effect upon the somnolent condition.

In November, 1888, his urine had become albuminous, and the muscles of his legs, and to a less extent those of his arms, had become subject to involuntary clonic contractions. The heart's impulse was weakened, its action without bruit, his pulse 90, and his body free from apparent œdema, though his countenance was somewhat swollen, and his whole physique was gross. His respiration numbered 18 per minute, and his temperature was subnormal (97.4°). His tongue was large and pale, and his bowels constipated. His urine was, as I have stated, albuminous (about $\frac{1}{15}$ of albumen), and its quantity greatly diminished. He was also incapable of taking exercise, having soon to desist from a sense of feebleness and breathlessness.

Medicinally, he was treated mainly with alkalies, including carbonate of ammonium combined with digitalis and nux vomica. On one occasion antipyrin was prescribed. Two to three grains of calomel with compound rhubarb pill were also prescribed, and acted as an efficient purgative. As, however, this line of treatment had proved futile on previous occasions, I advised a systematic course of daily massage at the hands of a person trained to that manœuvre.

On November 19th his drowsiness had diminished, and he complained greatly of thirst and dry tongue. About a fortnight later he was passing large quantities of urine, and his somnolence had almost entirely disappeared ; better in this respect than he had been for five years. He could also walk farther and with less breathlessness. On January 11, 1889, his muscular twitchings had disappeared, and his difficulty now was to fall asleep. Once at the end of the year he drank one tumbler of champagne, which sent him off to sleep immediately, and in his own words "he got as blue as could be again."

His sexual appetite, which had been almost abolished, returned with his general improvement.

On February 9, 1889, he considered himself well.—*Practitioner*, April, 1889.

Hinton (R. L.) on Viburnum Prunifolium as a Test for Labor Pains.—The writer called to attend a primipara of twenty, suspected the pains were premature, and gave, as has been his habit for many years, a teaspoonful of tr. viburnum in a little water. The pains disappeared, and in three weeks another summons brought the physician to the case. Again viburnum was in order, with the result of again relieving the pains for another three weeks, when her pains became bearing down, natural and regular, occiput presenting, and in three hours she gave birth to a fine large male child. The secundines came away promptly ; no hemorrhage. She made a good and speedy recovery. The writer never has post-partum hemorrhage, nor severe after-pains, and scarcely ever uses any thing but viburnum. He considers it the best remedy for both these

troubles, and never has puerperal fever or convulsions. He usually keeps his cases on this medicine till they are able to get up and dress.

He makes a saturated tincture from the green root, of which he uses about five gallons annually. He scarcely ever finds it necessary to remain with his cases longer than to see the child dressed, after the mother is cared for; and, out of thirty-three years' practice, he has only had three forceps cases; these were on account of disparity between the dimensions of the fœtal head and the pelvic outlet. Only one serious perineal laceration, one slight, both primipara.—*Therap. Gaz.*, June 15, 1889.

MISCELLANY.

Cones (J. A.) on Post-Mortem Sweating.—The patient, a male, aged forty-two, had for over nine months been suffering from albuminuria. The albumen never exceeded one fourth. Microscopical examination of the urine showed no casts, but abundant urates; there was no dropsy or ascites. Ten days before death he was suddenly seized with uræmic coma and left hemiplegia, which last persisted unchanged to the end. The temperature was normal until the last few days, when it was considerably higher, ranging from 102° to 104°, and so persisting to within six hours of death, when it steadily sank. All treatment to produce diaphoresis gave very slight and unsatisfactory results, and the skin, though not absolutely dry, was destitute of sweat to any extent during the earlier days of his fatal attack. Hypodermic injections of pilocarpine were given on four occasions, the dose being gradually increased; the last injection (one third of a grain) was given three days before death; this produced a fair amount of sweating for about twenty minutes, but was not repeated on account of the excessive bronchial secretion it on this occasion gave rise to. Forty-eight hours, however, before death the patient began to perspire profusely, and this continued without any interruption to the very end, even when the surface temperature was decidedly subnormal. The body, as usual, was washed and laid out on the bed, and four hours afterwards was removed thence to a bier, nothing unusual being noticed at the time of removal or before. When, however, the body was seen next morning—sixteen hours after death—it was at once noticed that the sheets and pillows on which it lay were absolutely saturated with sweat, and the skin felt moist and clammy; this continued for at least eight hours, but thirty hours afterwards it had apparently ceased, and the sheets, etc., were then drying. It was also noticed that post-mortem discoloration was well marked even when the body was first seen.—*Lancet*, May 25, 1889.

The Infectivity of a Corpse.—The question as to how far a corpse can be considered infectious is one concerning which very considerable difference of opinion exists. We have ourselves recently been the medium of the expression of the two sides of the matter—much, we fear, to the unsettling of the views of those who ventured to ask for a definite answer to a question that, in our present state of knowledge, really admits of no such definite response. In a northern town much controversy has recently arisen respecting the prohibition to admit into the cemetery chapel any corpse of a child dying of whooping-cough, lest the disease be transmitted therefrom to those entering the chapel. As regards this particular disease, the question of post-mortem infectivity might, perhaps, be decided by the bare fact that, as it is probable that the expired breath is the carrier of the "germ" or "virus," the risk of such contagion is reduced to a minimum when the act of respiration has ceased; and that only by assuming the retention of the infective agent in clothing, etc., could the corpse strictly be said to be infectious. Yet it is only a matter of opinion, and we are not aware of any facts to warrant the assertion that whooping-cough has never been so transmitted. We should, however, consider it as the *ne plus ultra* of sanitary caution to enforce such a prohibition as that named. Perhaps some of our readers could adduce instances of post-mortem infection in the case of whooping-cough or allied diseases, If so, we shall be glad to receive them, and they may then afford some basis for a line of action which must be thought to be somewhat arbitrary with present knowledge. It is otherwise with diseases where the virus is more likely to be given off from the surface of the body—as scarlet-fever, measles, or small-pox; but even in these cases records are very few of infection being transmitted by a corpse.—*Lancet*, June 15, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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OCCASIONAL REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M. D.

Gibney (V. P.) on Reproduction of the Entire Patella after Necrosis and Removal by Operation.—The patient was a boy, who at the time of injuring his knee by a fall, was seven years of age. Pain and swelling followed, and eight days after the injury a physician opened an abscess at the knee in the prepatellar region. A drainage-tube was inserted, and two weeks later Dr. Gibney saw the patient. There was then much discharge of pus, the parts were infiltrated, and the patella was movable over a limited area. A few days later he explored the parts and found the patella bare. On April 5th, the patella was turned out, and the wound treated antiseptically; fixation was obtained by a plaster-of-Paris splint, and the boy kept in bed three weeks. In July the function of the knee was fully restored. The patella is now as large as that on the other side.—*Med. Record*, April 13, 1889.

Richardson (M. H.) on Antiseptic Irrigation of the Knee-Joint for Chronic Synovitis.—Three cases are related in detail, treated by the writer and Dr. J. Collins Warren. The irrigating fluid was 5 per cent. solution of carbolic acid.

Although the immediate effects of this treatment are good, it is too soon to be able to say that there has been a permanent cure. It is quite important to use a needle of considerable size; and the best point to introduce it is just above the patella on the outer side.—*Boston Med. and Surg. Jour.*, May 16, 1889.

Mitchel (S. W.) on the Treatment of Pott's Paralysis by Suspension, etc.—The author narrates several cases of his father's and three of his own, and draws the following conclusions:

That suspension should be used early in Pott's disease. That used with care it enables us slowly to lessen the curve.

That in these cases there must be in some form a replacement of the crumbled tissues.

That unless there is great loss of power, the use of the spine-car or chair, etc., of John K. Mitchell, enables suspension, especially in children, to be combined with some exercise.

That no case of Pott's paralysis ought to be considered desperate without its trial.

That suspension has succeeded after failures of other accepted methods.

That the pull probably acts more or less directly on the cord itself, and that the gain is not explicable merely by obvious effects on the angular bony curve.

That the now well-known influence of extension in Pott's palsy makes it probable that in other forms of spinal disease, not due to caries, extension in various forms may be of value, as has apparently been of late made clear.

That the methods of extension to be used in these and in carious cases may be very various, only provided we get active extension.

That the plan and the length of time of extension must be made to conform to the needs, endurance, and sensation of the in-

dividual cases.—*Am. Jour. Med. Sciences*, May, 1889.

Davy (R.) on Excision of the Scaphoid Bone for the Relief of Confirmed Flat-Foot.—The writer does not accept Ogston's operation for the following reasons: 1. The operation appeared to be complicated; 2. The pegging of the bones was attended with inconvenience and was not free from danger; 3. The intrusion upon the astragalus brought the surgeon into rather too close a relationship with the ankle-joint, the integrity of which joint is a matter of much importance in flat-foot cases.

Instead he advocates the excision of the scaphoid bone, which is comparatively speaking, an easy operation, and the conformation of the bones of the foot suggest a tough, strong, actually cemented astragalo-cuneiform joint, united either by osseous or fibrous matter.—*Lancet*, April 6, 1889.

Golding-Bird (C. H.) Operations on the Tarsus in Confirmed Flat-Foot.—I would confine operations on the tarsus to those valgus cases in which not so much the deformity as the pain is the symptom which incapacitates the patient, and then only after a fair trial of rest followed by suitable appliances. Paradoxical though it sounds, it is none the less true that cure can be accomplished without the restoration of the arch; yet, in case in which operation was considered necessary, I should not be content with mere division of the tarsus or with mere ablation of the keystone of the arch, but with the latter combined with the former, whereby, without in any way adding materially to the difficulty of the operation, the divided parts on the inner edge of the foot may be easily brought into contact with each other without pegging, and the arch of the foot restored, and so a more perfect return to the normal state of the foot be ensured; although, as stated, a mere bone ablation suffices to cure the pain, the deformity remaining, to all appearances, the same.—*Lancet* April 6, 1889.

Moore (J. E.) in a Lecture on Double Equino-Varus, says: I wish to warn you against using a club-foot shoe in the treatment of these cases. I am sure that club-foot shoes have done more harm than good in this world. The prevailing method of treatment among amateur orthopædic surgeons is to cut the tendo Achilles and apply a club-foot shoe, expecting to overcome the varus in this way. This almost invariably results in failure and disappointment. The parents become discouraged and the child is left a cripple for life.—*Gaillard's Med. Jour.*, June, 1889.

Morton (T. G.) on the Treatment of Club-Foot.—In operating for equino-varus I first cut all resisting soft structures, then, if the foot cannot be brought to and held easily in a normal position, I make an incision on the outer side of the tarsus and remove a wedge with its base looking outward from the tarsal bones considered as a whole. In making this excision it is of the greatest importance that a sufficient amount of bone is removed; the apex of the wedge should come to a point almost or quite to the opposite side of the tarsus. With me the wedge will usually comprise: the anterior three-fourths of the cuboid, the whole of the external and middle cuneiform, with perhaps a shaving also from the anterior portion of the scaphoid, and the heads of the two outer metatarsal bones. If, when this much has been done, the foot does not come around to its normal position without the least resistance, I further remove the internal cuneiform, and, if also required, dissect out the remaining portion of the cuboid. For excising the wedge I employ ordinary cutting pliers in preference to the chisel, owing to the inevitable disadvantages incident to the bruising caused by the latter instrument, and because, in my hands, the cutting pliers have proved so much more accurate, easy of manipulation, and expeditious.—*Med. News*, May 18, 1889.

Phelps (A. M.) on Resection of the Knee-Joint; Organization of the Blood Clot.—The method described had been pursued in twenty-one cases of excision of the knee. The histories of two typical cases were given in detail. The first was a case of ostitis of the tibia in a girl, which went on to invade the knee-joint. The limb became flexed at a right angle, the disease continued active and he performed excision. After cutting the ends of the femur and of the tibia away as far as possible without entering the shaft, he found the abscess extended still deeper, and required scraping until but a shell of the head of the tibia and of the lower end of the femur remained. The bones were brought carefully together, wired, the Esmarch bandage removed, the cavity allowed

to fill with clot, and after three weeks, when the dressing was first removed, union both of bone and soft parts was found to have taken place; the union between the bones was evidently fibrous at that date. The second case related was similar.

To obtain a satisfactory result from organization of the blood clot, it was necessary to observe rigid antisepsis. The Esmarch bandage prevented hemorrhage during the operation. Do not apply rubber gauze, which tissue was most commonly placed over the cavity, but use Lister's protective; over this apply antiseptic gauze, then absorbent cotton, then plaster of Paris to fix the joint, and afterward swing the limb. Bichloride was used, but the cavity should be entirely free from this antiseptic before the final dressing. In twelve of the twenty-one cases there was firm bone-union; in six there was slight motion, and consequently fibrous union; in one there was much motion, necessitating a posterior splint; two patients were still in the hospital, the sinus extending into the thigh, although primary bone-union had been obtained at the joint. The average time of confinement after the operation was four weeks, while usually union took place in two or three weeks. In nineteen of the cases he employed Fenwick's method, cutting the bone in a curved line. A rubber drain was used, extending only under the skin, not into the bone cavity. He wired the bones together with silver wire in three cases; with iron wire in eleven, with or without a screw; in six cases no wire was used. The antiseptic was bichloride of mercury, 1 to 2,000 at first, afterward 1 to 5,000.—*Medical Record*, April 13, 1889.

Wyeth (J. A.) Some Cases of Osteotomy for Deformity of the Lower Extremity; a Case of Excision of the Knee.—The cases are reported in detail. The following are the conclusions:

Osteotomy for the correction of deformity is practically devoid of danger, and it accomplishes in a few weeks results which mechanical appliances would require years to achieve. Cuneiform tarsotomy is practically the only means now known for the more perfect restoration of the foot in severe forms of talipes equino-varus, in which the tarsus is ossified in mal-position.

Excision of the knee in modern surgery is rarely fatal, and should be employed in all cases of destructive osteo-arthritis of this joint, and to correct deformity due to anchylosis in bad position.—*Internat. Jour. Surgery*, April, 1889.

Heuston (F. T.) on Arthrectomy, or Erasion of the Knee-Joint.—The operation of arthrectomy is one which we may reasonably expect will occupy a prominent place in conservative surgery, as it holds out, in certain cases, a means of arresting morbid action in joints before the disease has advanced to such a stage as to render it questionable if the patient's life can be saved by any means short of an amputation, and although much has been obtained in this direction by excision, the results of which have during the past few years been so favorable, still we have in arthrectomy an operative procedure, especially in early life, and at an early stage of the disease, which is not so formidable, and has the advantage of giving in all probability a movable joint, and certainly no subsequent arrest of growth in the limb.—*Med. Press*, May 15. 1889.

McArdle (J. S.) on the Treatment of Tubercular Disease in and near Joints.—Four cases of tubercular disease at the lower end of the tibia, involving the ankle-joint, are reported in detail, in which trephining of the bone at the tubercular focus was performed; all were rapidly cured, except one which went on to a Syme's amputation; and four cases where the tubercular focus was located at the upper end of the femur were treated in a like manner and with like success. All were adults. In addition to the above cases the writer has trephined the lower end of the femur at the inner condyle in two cases; the upper end of the tibia in three; upper end of the humerus in two; the olecranon in three; lower end of radius in one; and astragalus in one. All the cases did well except the ankle already mentioned, one shoulder case where resection was demanded, and one elbow where anchylosis resulted.—*Dublin Jour. Med. Science*, April 1, 1889.

Phelps (A. M.) on the Management of Hip-Disease from an Anatomico-Pathological Basis. — The writer believes that all cases of hip-disease are attended with spasm of the muscle; that the spasmodic action of the muscles produces great interarticular pressure; and that the trauma resulting is the chief factor in producing destruction of the joint. That the inflammation begins as a simple

inflammation, either in the soft parts or the bony structures, subsequently becomes tubercular by inoculation, then purulent. Tuberculosis of joints is a local disease due to accidental inoculation and not to a constitutional or strumous condition.

Specimens were shown of joints of dogs immobilized by plaster of Paris for four months, which to all appearance were normal; and two cases of morbus coxarius were presented, one of which had been secured in a wire cuirass for eight months, and the other in a portable bed for five months, without movement. In both cases the joint was freely movable.

The writer agrees with Sayre, Taylor, Barwell, Marsh, and others, that spasm of the muscle should be overcome by extension. He also agrees with Thomas, of Liverpool, that every joint should be fixed and absolutely immobilized until all inflammatory action has subsided and a cure been effected. He does not believe that immobilization of the joint can be accomplished without extension; neither does he agree with the first-named gentleman that extension immobilizes a joint sufficiently to get the best possible results, but that a combination of the principles of fixation and extension should be the law. The combined longitudinal and lateral traction was then demonstrated, and the portable bed and the writer's hip-splint shewn.—*Med. Rec.*, May 4, 1889.

Judson (A. B.). Is More Conservatism Desirable in the Treatment of the Joint Diseases of Children?—The established method of treating the tubercular diseases of the joints by excision or scraping of the diseased bone is believed to be unnecessary in most cases, for the following reasons: That there are a great number of scarred but healthy cripples who have recovered without competent surgical attention; that it is generally impossible to locate the tubercular focus until suppuration has ensued, and the removal of one or more foci gives no certainty that there may not be other foci remaining; that amyloid disease of the liver and kidneys seems to be an expression of the constitutional vice rather than due to the pernicious course of the joint disease, and that it is not always or generally fatal; and that the performance of severe operations on the skeleton of a child is to be avoided on the ground that the patient is growing. —*Med. Record*, May 18, 1889.

Taylor (H. L.) on the Prevention and Treatment of Crural Adduction.—Most of the moderately advanced cases of hip disease that I have examined have presented an adducted thigh; and this is equally true of those who have first applied after the cure of their disease. Drs. Shaffer and Lovett in their investigation of the "Ultimate Results of the Mechanical Treatment of Hip-joint Disease," found 10 to 30 degrees adduction in nearly one half of the cured cases examined to determine this point. There is no doubt that the proportion of adducted thighs in old cases cured by less thorough methods is considerably greater. Typically deformed old hip cases form one of the commonest and worst classes of the permanently crippled, and as seen on our streets, more than three quarters show an adduction easily observable in the carriage of the body; in addition the thigh is usually flexed and inverted, and the deformity and disability are sometimes so great as to doom the sufferer to crutches for life.

Several cases are then narrated, and the writer goes on to describe and illustrate the modern form of Dr. Taylor's traction splint, jointed supporting splint, median adduction splint, and long median abduction splint.

In the discussion which followed the reading of Dr. Taylor's paper, Dr. Gibney asked whether the motion in the hip which was present when the case presented itself, was progressive or not, because the statistics of Drs. Shaffer and Lovett showed that the amount of motion did not increase after the cure of hip-joint disease. Dr. Taylor replied that in the case referred to the amount of motion had remained practically unchanged.

Dr. Shaffer did not know why we have adduction when we suppose our cases to be cured. When Dr. Lovett and he were studying the cases they reported, he was struck by the fact that cases supposed to be cured, and who left the dispensary in pretty good condition, with a tolerably straight limb, without much adduction, after eight or ten years' release from active treatment, would show on examination not only an increased adduction, but also lessened mobility. He was inclined to believe that adduction occurs only in cases where there is a condition of disease which has not been absolutely cured.

Dr. Phelps thought that muscular spasm

was only a symptom of the disease. When the muscular spasm did not yield to traction, combined with fixation, he advocated section of the muscles to overcome the deformity. Extension is made in a line corresponding with the axis of the neck of the femur.

Dr. Ridlon said that it should be our aim to prevent this deformity of adduction as well as to cure it when the cases from some one else come to us with it. He was very glad that Dr. Taylor so frankly brought the matter forward, and stated that the majority of these cases treated by traction with portative apparatus do get well with flexion and adduction. When a patient comes to us with flexion or adduction, the particular method of treatment adopted will depend upon whether it is cured or not. If it be cured, and the adductor muscles are shortened and not in spasm, and the leg shortened from shortened adductor muscles, and not from spasm, he saw no reason why those adductor muscles should be stretched rather than divided. If the case be not cured, and the adduction be due to muscular spasm, then we should treat the joint disease rather than try to relieve the adduction; and upon that comes up the question whether traction in any line is advantageous or even harmless in a case of hip disease with adduction. It seemed to him that traction upon a leg whose adductor muscles are in spasm does produce some pressure at the point of disease, whether that point be at the articular surface or at some distance from the articular surface; but he did not think we were unanimous as to whether that pressure was harmful or not. Involuntary muscular spasm means that there is still bone disease, and should be an indication for keeping the part perfectly at rest; there should be absence of motion and absence of pressure, whether from superincumbent weight or muscular spasm.

Dr. Phelps, in answer to a question from Dr. Shaffer, as to what was his rule in dividing muscles, said: Any muscle which can be stretched under ether, or which by extension for a short time will allow the deformity to be overcome, he should not think of dividing; but if, in a case of hip-joint disease of one or two years' duration, the tensor vaginæ femoris, the fascia lata, and the adductors were tense and would not yield to force under ether, he would cut these tissues.

Dr. Judson said that it appeared to him probable that the limb, as a rule, assumes that position which the patient finds most habitually comfortable and convenient. In the early stages of the disease the deformity was easily corrected; in the later stages it was far more difficult.

Dr. Taylor, in closing the discussion, said that the paper was on the subject of adduction, and not on the treatment of hip disease, which is a very much broader subject, and that the earlier forms of adduction from reflex muscular spasm required nothing more than the proper traction treatment. The plan of treatment which he recommended was applicable to cases where there was structural shortening of the muscles, connective tissue, and ligaments, and where in many there were firm adhesions in the joint. He was far from thinking that the majority of patients treated by what he would call proper traction were left, when cured, with adducted thighs.—*Med. News*, March 23, 1889.

THERAPEUTICS.

Sulphur Fumigation.—An anonymous author thus writes to the *Brooklyn Med. Jour.*, July, 1889:

"Last October one of our children was taken with scarlet-fever. The doctor advised us to send two of the younger children away, and by confining the sick child to a room in the third story of the house lessen the chances of infection. The instructions were immediately obeyed. The two children were absent from the house nearly three months. The sick child had entirely recovered, and a system of fumigating was ordered. Every thing was removed from the room where the sick child had been; in fact, from two rooms, the parlor and bedroom immediately adjoining. Carpets and other material were burned. A quantity of dry sulphur was burned in the rooms, about two pounds, which kept the rooms in a state of suffocation for several hours. Then a complete washing of floors and every article of furniture was carefully performed, the walls and ceilings being thoroughly cleaned, nearly a gallon of carbolic acid being used in the operation. The bedstead and other movables were revarnished, and after a readjustment of material another burning of sulphur, about one pound, was proceeded with. A

considerable quantity of sulphur was also used in the kitchen on the ground-floor, and every suggestion of our medical adviser was punctually attended to.

"The sulphur was burned partly in a coal-shovel set in the stove, the door of the stove being open and the damper in the stove-pipe shut, and another quantity in the other room in a smaller shovel set in a coal-scuttle. No water was used, and there was no water in the rooms at the time; this I am sure of. The burning of the sulphur was exactly as the doctor had instructed us. The area of the floor, 36x18 = 648, about 11 feet high, = 7,128 cubic feet, minus the hallway, 6x24x11 = 1,584 = 5,544, or about 5,000 feet divided into three rooms. I am not quite positive that the quantity burned on the first occasion amounted to two pounds. Possibly one half pound was used in the kitchen, which would make one and one half pounds in the two rooms, or probably more. On the second occasion the quantity used was perhaps not more than half as much. We were not particular about the quantity. There was more used than the doctor thought sufficient.

"The doctor recommended leaving the windows open during some of the coldest days in December, and two days particularly the temperature in the rooms was at least ten degrees below the freezing-point. After the doctor had assured us that it was perfectly safe to bring the children home, we burned another quantity of sulphur, about one half pound, dry, and delayed the coming home about a week.

"They came home on Christmas Day, and, as you may imagine, it was a kind of merry Christmas with us. Just eight days after, one took the fever, and on the third day succeeding the other followed. One peculiarity was that neither of the latter cases resembled the first; for, while the first case had the fever accompanied with intermittent delirium, the other two were quite rational, but had severe affections of the throat. One of the latter cases was particularly serious, the doctor hardly expecting recovery. They all recovered.

"I may add that during the period the latter two were afflicted, every one in the house was more or less affected with sore throat, even two or three visitors also becoming similarly affected.

"I cannot, therefore, place much faith in dry sulphur or carbolic acid as disinfectants. It would have been a great saving of trouble to us if the children had been permitted to stay at home and had the disease together."

The Antiseptic Action of Ammonia.—One of the facts now becoming abundantly substantiated with regard to the effect of organisms on the organic bodies on which they live (albuminoids, etc.) is that the products of bacterial activity tend to limit and finally to destroy the vitality of the growing organisms. Not only is this so with bacteria, but it is now well known, and can be readily demonstrated by experiment, that the products formed by digestive ferments from albuminoids or carbohydrates tend to "choke" ferment activity, which indeed revives when the products are removed, as, for example, by dialysis. Ammonia is one of the commonest products of putrefaction. It is formed not only by the action of putrefactive bacteria on albuminoids, but is a result of the decomposition of urea, which occurs from the action of the bacillus ureæ. Gottbrecht has lately tested the anti-fermentative action of ammonia. In his experiments he did not use the gas itself, but carbonate of ammonium, which, although less volatile than the gas, readily develops ammonia. It was found that a 2-per-cent. solution of this salt delayed the decomposition of portions of fresh organs for nine days, a 5-per-cent. solution for nineteen days, while a 10-per-cent. solution delayed it for sixteen days. In mixtures in which decomposition had already occurred, ammonium carbonate added to the amount of 5 per cent. after a time killed the organisms; while a 2½-per-cent. admixture of the salt diminished their activity. On the other hand, it was found that smaller proportions of ammonium carbonate, ¼ to 1 per cent., not only did not diminish, but actually increased the activity of the organisms, so that putrefaction became more rapid. This is only another example of a very large class of substances, which in small doses increase activity, in large doses diminish it; many of the drugs which act on the heart have this action. It might be considered that the action of carbonate of ammonium on putrefactive changes was due to the state of alkalinity produced in the liquid; but that this is not so is shown by the fact that sodium carbonate added to the same degree of alkalinity does not possess any antiputrefactive action.—*Brit. Med. Jour.*, June 29, 1889.

Croskey (J. W.) on Sodium Silico-Fluoride.—The author concludes that sodium silico-fluoride is:

1. An efficient antiseptic.

2. That a solution of one grain to an ounce of water is quite strong enough for ordinary purposes; in that strength being apparently unirritating.

3. That the solution is unirritating to the hands, which is no small advantage to those operators whose fingers are easily irritated by ordinary antiseptic solutions.

4. That a solution of one grain to the ounce may safely be used to syringe out closed cavities, even where the operator cannot be certain of all the fluid returning.

5. That it acts very efficiently as a deodorizer of the hands, after examining carcinoma of the uterus or rectum, by steeping the hands in a saturated solution. The odor is removed more efficiently than it is by any solution with which I am acquainted.

6. That a very convenient and comfortable antiseptic poultice may be made by soaking gauze or absorbent wool in a hot solution (ten grains to the pint), wringing it freely of excessive moisture, applying it to the wound, and covering it with gutta-percha tissue.—*Times and Register*, July 6, 1889.

Purdon (C. S.) on Intolerance of Antipyrin.—On May 31st last, I prescribed for a case of sciatica, occurring in a man aged about fifty years, five-grain doses of antipyrin, to be taken three times daily. He took the first dose (which, he says, was not quite a full one) at about 11.30 A.M. He instantly experienced a sensation of tingling and burning in his gums, which rapidly extended to the throat and nose, accompanied by sneezing, running from the eyes and nostrils, dizziness, complete loss of vision, a feeling of numberless pins pricking him down each side of the neck, tightness in the throat, and dyspnœa. His wife came to his assistance about one minute after he had taken the dose, and saw that his face was much swollen and "black." The pin-pricking sensation extended rapidly down the right side of the chest and abdomen, and was particularly severe in the right side of the scrotum and right testicle, and was also felt in the legs and feet—severely in the right, and slightly in the left.

He next experienced a sensation as if the contents of his thorax and abdomen were being forcibly drawn upwards towards his throat, and the right testicle towards the abdomen; so that, he says, he "was drawn in a ruck," and, being no longer able to stand, he fell on the floor. He trembled violently all over, and had cramp in his right arm and head.

I was hurriedly summoned, and arrived at 11.45 A.M., fifteen minutes after he had taken the dose. I found him sitting on a chair with his head resting on the back of it, declaring he was unable to remain in a recumbent posture. His face was of a dusky red color; his nose, lips, and eyelids, were so swollen as to render his features quite unrecognizable; eyes suffused and running, breathing hurried and difficult; he was trembling violently all over, and the fingers of his right hand were clenched in the form of a claw. Pulse scarcely perceptible.

I at once gave him some brandy, when he immediately expressed himself as better. He spoke in a thick, husky tone of voice, and complained of dizziness and a fulness in the throat. I looked into his mouth and found the soft palate red and swollen, the uvula swollen to an enormous size and œdematous; the back of the pharynx was also swollen and red. No rash appeared on the skin.

The symptoms gradually subsided, with the exception of soreness and a sense of fulness in the throat, difficulty of swallowing, huskiness of the voice, and dizziness—all of which continued, more or less, till bedtime. He complained for some hours of a peculiar taste in his mouth, coming on at intervals, which he compared to "the sulphur-gas in the chemical works" in which he had been employed. The following day, with the exception of a slight headache and loss of appetite, he had completely recovered.—*Br. Med. Jour.*, June 15, 1889.

Antipyrin Epilepsy.—All cases of poisoning by this drug are important, since, from its undoubted utility not only in fever, but also in neuralgias, it has become very popular. Tuczek has recorded a case in a boy nine years of age, to whom the drug was given to allay the paroxysms of whooping-cough. The patient had never suffered from convulsions, rickets, or worms. The dose given was about seventeen grains daily in three doses for the space of three weeks. At the end of this period the patient was seized with vomiting, and passed

into a state of somnolence, ending in deep sleep. Rapid ensuing epileptiform spasms followed, sometimes general, sometimes unilateral, accompanied with grinding of the teeth and jactitation, arhythmia of the cardiac beat, and dilatation of the pupils. A macular eruption appeared on the skin, and the temperature became subnormal, while the pulse was slow and tense. On the third day of poisoning, consciousness began to return, the convulsions diminished in severity, and ceased entirely on the fourth day. For a few days the child was depressed, but completely recovered. It is interesting to find that during the whole period of poisoning there was acetonuria—a condition which is ascribed by Tuczek to the increased destruction of the albuminoid constituents of the body caused by antipyrin. During the poisoning there were, as might be expected, no attacks of whooping-cough, but afterwards the paroxysms returned with increased severity, and lasted for some months.—*Br. Med. Jour.*, June 29, 1889.

Prentiss (D. W.) on an Unusual Idiosyncrasy Attending the Use of Ergot.—The patient, a brunette 41 years of age had always been in good health excepti. uterine disorders; married twenty-two years, never pregnant. Has had uterine fibroid tumors for eight years. Previous to 1873 had three attacks of pelvic cellulitis. The tumors were discovered in 1881, since which date she has taken ergot almost constantly, either in form of fl. extract or by suppositories, to control the menorrhagia. The fluid extract was given in doses of from 15 drops to a teaspoonful three times a day for eight years. The effect was very decided in controlling the hemorrhage, the larger dose being used when the hemorrhage was severe, and the smaller dose in the interval.

The tumors became smaller under its use and the patient's life was rendered more comfortable, but it produced a peculiar effect to which I wish to call attention, never having observed the same before. This was the same whether taken by the mouth or by suppository.

This effect was uniform and very marked, and I have not seen it referred to in the literature of this drug. It was characterized by a peculiar depression of spirits with hysterical phenomena, and was more marked when full doses of the fl. ext. were taken, less marked when using the suppositories of ergotin. After taking ergot for three days she feels like crying all the time; then, on the fourth day, she is ill-tempered and displeased with everything and wants to quarrel; will lie in bed and cry all day. All this while her natural disposition is just the opposite—even-tempered and exceptionally pleasant.

The family soon came to recognize this state of mind and respect it accordingly. Husband and servants were careful not to aggravate it, and even the little adopted daughter would say, "Mamma has been taking ergot, don't notice her."

The effect here noticed occurred constantly following the ergot, and was undoubtedly produced by it.—*Jour. Am. Med. Assn.*, June 29, 1889.

Toxic Action of Pyrodine.—At a meeting of the Medico-Chirurgical Society of Padua on March 30th, Dr. Lui Cantù gave an account of the effects produced by pyrodine in a case which he had had under observation. The patient was a lad, aged nineteen, who was suffering from tetanus; pyrodine was given to the amount of fifty centigrammes a day. On the third day the urine was intensely dark red in color, and was found to contain methæmoglobin and a large quantity of urobilin, besides masses of amorphous reddish-brown granules. The red corpuscles were discolored and showed little tendency to form *rouleaux*, and numbered 2,500,000 per cubic millemetre. Under diet, consisting largely of milk, all toxic symptoms disappeared in twelve days, but the patient remained in a state of grave anæmia. The pyrodine did not lower the temperature, and had no effect on the tetanic symptoms. Dr. Cantù concludes that pyrodine is a powerful blood-poison, with a destructive action on the red corpuscles analogous to that of chlorate of potassium, pyrogallol, etc. He maintains that it has no advantage over the antipyretic and nervine remedies already known, and absolutely condemns its employment.—*Br. Med. Jour.*, June 15, 1889.

Phillips (G. A.) on Cases of Wild-Parsnip Poisoning.—Botanically and in physiological action this plant resembles the water-hemlock. It is the *pastinaca sativa* of Gray.

The poison takes effect in direct ratio to the rapidity of the digestive powers in children, about two hours after the ingestion of the root. The symptoms are flush-

ing of the face, mental dulness, followed soon by twitching of the extremities and severe convulsions, with coma, pupils widely dilated, respiration shallow, pulse weak, rapid, and thready, tongue dry and swollen. Treatment was by opium and prolonged etherization, after emetics and enemas.

Death occurs in cases not promptly relieved. Strong infusion of the root injected under the skin of a cat had no other effect than to widely dilate the pupil.—*Boston Med. and Surg. Jour.*, July 4, 1889.

PATHOLOGY.

Whitney (J. W.) on a Case of Remarkably High Temperature.—William McQ. was admitted April 28, 1885, to the Brooklyn Hospital. The diagnosis made was intermittent fever. His age was forty-eight; United States; widower; merchant.

Two or three months ago the patient was treated here for delirium tremens. Soon after leaving hospital he became partially paralyzed, and was taken to the Cumberland Street Hospital. There he developed intermittent fever of the most extraordinary type. Every third day his temperature would go up to 108° F. and 113½° F.

April 29th.—His chills last about three quarters of an hour. His story was not believed until yesterday, when temperature was taken at two different times, and was first 110° F.; second, 113° F.

May 1st.—He remained in this condition half an hour. Last night had hard chill; shook the whole ward; temperature 112° F.

May 2d.—Temperature 99° this morning. Says he feels sore. During the chill and also the fever that followed, he seemed to be almost delirious; very restless; would kick the bottles out of bed, etc. Pulse was 100; respiration 38.

May 3d.—To-night he says he will have another chill; was called at 2 A.M. Very light chill, followed by temperature 112°. The skin does not feel warm above normal. Seems to be quite weak. In bed most of the time, yet not necessarily so.

May 4th.—These "hot flashes," as he calls them, occur several times every day, as was ascertained by taking his temperature every half hour for the twenty-four hours. The state of his mind seemed to have something to do with the flashes, *e. g.*, he became angry at the nurse several times on different occasions, and always had a rise of temperature following it.

He gives a history of intermittent fever, contracted in Georgia ten years ago.

These hot flashes came and went until May 17th. After that he never had any rise of temperature. Many times he would complain of feeling chilly, but no marked rigor followed. Following some of these flashes he would complain of pain in his back and head. Often the muscles would twitch on different parts of his body so much, that at times it was impossible to take his pulse. These flashes lasted from five to thirty minutes. He could tell the moment his temperature dropped or went up. Every day's observation seemed to point to a central lesion and not one of fever. Before he came here he was delirious before and during the rise in temperature, but later on he was little disturbed. He was always exceedingly nervous, so much so, that temperature could not be taken by mouth. He was a wreck from the effects of alcohol, both physically and morally; was constantly complaining, and would sulk for days if the nurse reproved him.

Treatment.—At first he was giv[illegible] large doses of quinia sulph.; that was followed by Warburg's tincture, ʒ i. doses. The treatment he was kept on most of the time was Fowler's sol., ♏ iv., t. i. d., hypodermically. His appetite was fairly good; bowels regular most of the time; slept very well. He had only a few chills occurring every other day, but the fever came and went with every change of the wind.

He was discharged May 24th for insubordination.—*Brooklyn Med. Jour.*, July, 1889.

Hulke on Suicide, Apparently Begun by an Attempt to Cut Off the Head from Behind, etc.—A cobbler, aged twenty-eight, was admitted on April 11, 1889. He had a swarthy, ex-sanguine complexion; his face was deeply scarred by small-pox, and its expression wandering; his voice was reduced to a husky whisper; his clothes were soaked with blood. Crossing the junction of the occiput with the nape of the neck were three deep, jagged, incised wounds. A jagged, incised wound crossed the front of the throat, extending from the posterior border of the left sterno-mastoid muscle to the middle of the right muscle of this name, partially dividing both

these muscles, severing the depressors of the hyoid bone, and cutting through the thyroid cartilage a little below the level of its middle. In the right ala of this cartilage was a triangular defect, a piece having been cut out; whilst in the left ala were two deep cuts intersecting one another at the keel formed by the junction of the alæ. Through the above defect in the right ala the respiratory movements of the glottis were plainly apparent. All bleeding from this large wound had ceased, except from the right external jugular vein. In the left front of the chest were four wounds—stabs. Of these, two seemed to be superficial, whilst from the others air issued, proving the pleural sac to have been opened. One of these penetrating wounds was in the third costal interspace, about an inch and a half inside the nipple line, whilst the other was in the fourth space in the nipple line. This side of the chest was hyperresonant, and respiratory sounds were absent, except posteriorly at the base, where they were very faint and accompanied with coarse râles.

The wounds on the chest and on the occiput were washed with a solution of carbolic acid in water (5 per cent.), dusted with iodoform, and closed with compresses of boric lint. The wound in the neck was similarly cleansed, and lightly covered with a couple of layers of carbolized gauze.

During the next two days he sat up in bed, took nourishment freely, swallowing without difficulty, and passed quiet nights. On the 14th at 11 P.M., he sprang suddenly from the bed, knocked down the nurse and the male attendant in charge of him, and tried to escape from the ward. Hyoscyamine $\frac{1}{60}$ gr. quieted him. On the 17th the chest wounds were found to be closed, and that in the throat had contracted. On the 18th, at 3 A.M., he again became restless and violent; at 4:30 A.M. he was slightly convulsed and comatose; and at 7 A.M. death occurred.

At the necropsy on the following day, one of the cuts in the nape was found to have penetrated to the occipito-atloid ligament. The stab in the third intercostal space had pierced the upper lobe of the lung to the depth of three quarters of an inch. The edges of this wound in the lung were glued together by fresh lymph; the lung around the wound was not solidified. There was not any pleuritic effusion. The lower lobe of this (the left) lung was intensely engorged, and its bronchi were filled with muco-purulent fluid. The right lung was very congested, and it contained several areas plugged with inhaled blood surrounded by excessive engorgement. The laryngeal wound had passed between the false and the true cords. The occurrence of the patches of hemorrhagic infarction in the right lung only was attributable to the collapse of the left consequent on the opening of the left pleural sac.

The forensic interest of this case is its chief importance, it being beyond the slightest doubt that the wounds were self-inflicted.—*Lancet*, June 22, 1889.

Park (R.). A Study of Acute Infectious Processes in Bone.—The author concludes:

I. There is no one specific microbe for the production of acute infectious processes in bone.

II. Most, if not all, of the staphylococci can cause them. Exceptionally, the streptococci may exert such an influence. So may tubercle bacilli and those of typhoid.

III. Commonly, when these latter are met with, we have to deal with a mixed infection, the pyogenic cocci being the final and active destructive agents.

IV. Of all forms, the staphylococcus aureus is the most pernicious.

V. The parasitic infection may occur through the ears, eyes, nose, mouth, pharynx, respiratory passages, mucosa of the alimentary canal, or skin; or, in other words, through any lesion of the external or internal body surfaces. Furthermore, from any subcutaneous phlegmon, however small.

VI. The infection need not necessarily have been recent. The staphylococci and the bacilli of tubercle have the property of hibernation, so to speak, and their period of latency is one of almost indefinite length; this is especially true of the former.

VII. Some predisposing condition will be usually found to have favored the entrance of the infectious germs into the system and their lodgment in the localities where they manifest most activity.

VIII. Of the general causes which favor their entrance the diathetic conditions, such as the tubercular, and the dyscrasial, like the syphilitic, also the post-febrile, play a most conspicuous part. Age, *i. e.*, childhood, is also always a predisposing cause.

IX. Of the causes which favor lodgment

in particular localities, exposure, exhaustion, strain, and more marked traumatisms are those usually met with.

X. Pathologically, a case of acute infectious osteomyelitis becomes within a few hours a case of localized pyæmia, with all that the term implies; and this within a few hours more may become so generalized that a patient may die, even within thirty-six hours after noting the first symptom, of overwhelming septic intoxication.

XI. Acute infectious periostitis may run almost as acute a course, locally, as the same grade of osteomyelitis; but, inasmuch as pus finds more readily an outlet, it seldom leads to as rapid general disaster.

XII. A final conclusion in a therapeutic direction may, perhaps, be permitted here. No matter how former surgeons, like Demme and Chassaignac, disputed the matter, there is to-day but *one* safe and rational treatment, and that is, early and radical operation. These cases have been too often considered to be acute rheumatic affections, and many lives and limbs have been sacrificed to this diagnostic error. Our books and teachers need to give more exact instruction in this respect. When students are taught to recognize early the gravity of these conditions, they will learn that which, in many schools at least, they are not taught to-day. And now that we no longer dread as we did a combat with these insidious and invisible foes, there is no longer any reason for hesitating to operate early, since it offers our sole and almost only hope. Early, radical, and antiseptic attack constitutes, then, the therapy of the diseases to which I have invited your attention.—*Amer. Jour. Med. Science*, July, 1889.

Keirle (N. G.) on Death from Electricity.—The case in which the post-mortem was made was a lineman. The wire on which he was working was not insulated, and it was given in testimony at the inquest that workmen frequently take hold of the wire with no effect except a slight "shunt." It seems that he had cut the wire and then took hold of the two ends. This connected the current, and instant death was the result. When the man was seen, he was very stiff. A wound was observed between the thumb and index-finger of the right hand. There was no loss of substance found radiating from this wound; there was a brown eschar.

A careful post-mortem was made. The appearance which was especially noticeable was the absence of blood in the heart. The right side was flabby, the left was contracted. Blood flowed freely on removing the calvarium, which might account for its absence in the heart. The lungs were congested, and the blood in them was fluid.

In a second case the corpse was charred completely. The body was found lying upon its face with its legs flexed. The articulation of the astragalus was laid bare. The heart escaped injury. All over the body were seen patches of hard pinched-like areas with little clefts between them. Some thought the position was due to the man crawling along the floor, others suggested that it might be due to stimulus to the muscles caused by the fire.

The post-mortem showed that the parietal bones and bones in general were reduced to a calcined condition. The dura mater was untouched; the brain appeared somewhat rough, as if rubbed with something. The frontal sinus was open, as was also the antrum. The eyelids were charred; when lifted a yellowish substance was observed. The ball was punctured, the aqueous humor came out, and both lenses were found to be white. The lungs were congested, larynx and trachea red, and contained a fluid stained with soot and smoke. The cause of death was suffocation.—*Med. Times*, Jan. 15, 1889.

Harland (W. G. B.) on Lipoma, with History of Heredity.—Mary S., about twenty-five years of age, well nourished, of scrofulous diathesis. About nine years ago the patient fell and sprained her back, and shortly afterwards a small lump appeared over the angle of the right scapula. This slowly and steadily increased in size to the present time, causing great inconvenience and discomfort to the patient from its position, being subjected to constant rubbing and irritation from the upper edge of the corset.

On examination there was felt imbedded in the subcutaneous fat a tumor the size of an orange, placed just below the angle of the right scapula, freely movable, obscurely lobulated, and semi-fluctuating.

The father of this girl stated that both himself and one of his sisters suffered from similar growths, and that several of his ancestors had suffered in the same way, the lumps in all cases being smaller and not being placed on the same part of the body.

Examination of this man showed a small fatty tumor of the arm.

On May 2d, Dr. Edward Martin, assisted by his students, extirpated the growth. A long semilunar incision was made just below the tumor, the latter was rapidly dissected and torn from its bed, the rather free bleeding was checked by half a dozen ligatures, and the wound, which was large and deep enough to receive and conceal the open hand, was closed without drainage by means of cat-gut sutures. The case ran a typical apyretic course, and in nine days the dressing was removed, showing a wound completely healed except a few points of granulation about a suture.—*University Med. Mag.*, July, 1889.

Stockton (C. G.) on the Passage of Portal Blood into the General Circulation, and its Probable Relation to Toxæmia.—The author claims, first, that the occurrence of inosculations between the portal and general systemic veins was to a certain extent normal; that these intercommunications might as anomalous conditions be extensive; that obstructive liver diseases, or perihepatitis, might result in the production of new anastomoses.

Second, that the blood of the portal vein was toxic in character, at times extremely so. The lower pressure of the blood in the portal than in the general venous circulation was held to be the reason of prevention of toxæmia in ordinary cases. In case of bed[illegible] in the portal circle, portal blood [illegible]stemic veins without filtering through t[illegible]er, thus inducing toxæmia.

Were it [illegible]r the action of the blood upon the substances which are carried into the circulation, this would prove more disastrous than it does. The blood in health possessing the power of self-purification to a certain extent, serious toxæmia did not often follow until the integrity, the resistance, of the blood was diminished by long effort or by disease, and then toxicity was made evident by symptoms.

Reference was made to the coma of cirrhosis, to propeptonuria, glycosuria, and certain cachexiæ. The lower pressure in the portal vein was proved by experiment of Prof. Julius Pohlman upon lower animals.—*Boston Med. and Surg. Jour.*, July 4, 1889.

Buckell (W. R.) on a Case of Vaccine Vesicle on Tongue.—Mrs. C., aged 26, came to me with a swelling about the size of a hazel-nut on the dorsum of the tongue about half-way back and a little to the right of the middle line. The swelling was rather hard to the touch, of a grayish color, with a central depression, about a line in diameter, of a dark color. A little to one side of this depression were two minute openings, through which a little yellow discharge oozed on pressure. Just in front of the main swelling was a small grayish pimple.

The history of the case is as follows: On April 5th she ran a fish-bone into the tongue, the place remaining sore for some time. Two days after, on April 7th, her baby was vaccinated; and on April 14th, seven days later, matter was taken from the vesicles. On this occasion the child cried so much that the mother kissed it on the arm at the site of the vaccination, very possibly, as mothers often do, taking the arm partly into her mouth. On April 20th she first noticed the swelling on the tongue. On the 26th, when I first saw her, the vesicle was evidently past maturity. On the 30th "a large piece like white skin" came off. May 3d a small, healing sore about $\frac{1}{8}$ inch in diameter was all that remained.—*Br. Med. Jour.*, June 22, 1889.

BOOK NOTICE.

The Errors of Refraction.—By Francis Valk, M.D., etc. Pp. 245, 8vo, Numerous illustrations (some in color). G. P. Putnam's Sons, New York and London, 1889. Price, $3.00.

This book shows good care both in study and in the judgment of its author. Each point is followed out in a clear, simple, and direct manner, making it easily understood by the reader and student. Quotations from other authors have been given rather moderately, strengthening the points taken by the writer. This method has the great advantage of clearness, all doubt of the writer's position being avoided. In these times of prolific authorship the temptation seems very great towards excessive quotation; the ideas or experience of those holding positions opposed to the writer being frequently given such prominence that the reader is confused and doubtful of the position held by the author.

We would especially draw attention to the chapter upon muscular asthenopia and that on astigmatism as worthy of the student's time, in careful reading. There are points which one would like more freely developed. But these are in minor details and would have perhaps detracted from the clearness of the topic. As examples of this we would mention the distinction or description of lenticular astigmatism. In the method of detecting muscular asthenopia of the external or internal recti the dotted line is directed to be held vertically. We have found that many cases of two and even four degrees of insufficiency are overcome, which when the dotted line is held horizontally is perfectly evident, and cannot be overcome by the patient until the fitting prism is used. A. T. M.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

Baldy (J. M.) on the Complications Following Abdominal Section.—From the fact that so little of the dark side of abdominal surgery has been of late brought to the notice of surgeons in the current periodicals, the faith of many medical men in the value of the original operation is shaken when they chance to observe some of the annoying or serious results to which occasionally it gives rise. Also untrained surgeons are led to attempt such operations, which would not be the case if all these complications had been clearly brought to their notice.

The author considers the average of ventral hernias following abdominal section to be thirty per cent. This may be a cause of as much or more trouble than the original disease. The preventive treatment lies in securing perfect apposition of the cut edges of the deep fascia and muscular tissues by careful suturing of the wound.

Abdominal fistula often follows the operation, being caused by use of a drainage-tube, rupture of an abscess in the line of the wound, or the extra-peritoneal treatment of the stump in hysterectomy. The drainage-tube, if required, should be removed as soon as possible; if abscesses form they should be freely opened. Fæcal fistula is not common, but is a most serious complication. Ordinarily the gut is so bound down by adhesions, and is so deeply seated as to render it most difficult to reach it, and then the operation for its closure is one of the most serious in abdominal surgery. Care should be taken in separating adhesions to the gut and attention to after-treatment, as the sloughing of a portion of the gut at the point of the torn adhesion is the usual cause. They had best be left alone under ordinary circumstances.

Persistence of the old pain or development of a new pain is a common occurrence, and is usually due to the formatic of inflammatory adhesions after operatio These also may cause intestinal ob- ed. tion. The administration of thus keeping up peristalsis, a na, employment of opium is th mbo of preventing these adhesions.

Œdema of the lower extremities often follows operation, but ordinarily disappears in time.—*Med. and Surg. Reporter*, April 6, 1889.

Routh on a Case of Erotic Feelings Preceding and Following Epilepsy.—The patient was a lady whom he had first seen in 1874. She was then unmarried, and was suffering at that time from leucorrhœa, with ulceration of the cervix and follicular vaginitis, also dysmenorrhœa. She complained at times of something very much like fits. She was markedly hysterical. She had been addicted to habits of masturbation. She was now married, and had had three children. Since her marriage the fits had recurred, and sometimes followed conjugal relations. They were always stayed by valerian and the bromides. He read his notes on the case on October 18th. The catamenia had been unusually

copious, but had lately been very irregular, and finally stopped, and headache and symptoms of confusion of intellect had followed. She was then forty-five. The uterus was very large, reaching above the umbilicus. The passage of a sound into the uterus was very painful, and brought on a fit. He ultimately decided to try the effects of the negative electric current to re-induce a menstrual flow, but on the occasion on which he did this she developed strong erotic symptoms, and had an epileptiform attack, after which she again became aggressively amorous to a lady to whose care she was for two hours consigned. The author pointed out that these were precisely the circumstances under which charges were made against medical men, and though his long-standing relations with this particular patient prevented any thing of the kind in that case, it was evident that the situation was full of danger under other circumstances.—*Provincial Med. Journal*, May 1, 1889.

Hadra (B. E.) on Vaginal Prolapse, Rectocele, and Cystocele.—Referring to recent contributions to the literature of the treatment of injuries of the pelvic floor by Dudley and Marcy, the author emphasizes their views as to the importance of the perineal muscles as uterine and vaginal supports, but considers the fibres of the levator ani which pass between the vagina and the rectum as the most important of these. To the attachment of the vagina and the cervix uteri, and to the sacral fascia, he ascribes the principal support of the uterus, provided that the vagina be also supported by the levator ani and the pelvic fascia. The transversus perinæi serves as a buttress to the levatoric attachment. The chief cause of vaginal prolapse is the submucous detachment of the vagina from the cervix and the sacral fascia during labor, this being due to pressure by the child's head.

Detachment of the vaginal wall from its levatoric support results in rectocele and more or less vaginal prolapse. This is to be remedied by dissecting up the vagina from the rectal wall to a sufficient extent, sewing together the separated portions of the levator ani by means of a buried animal suture beneath the vaginal flap, which is either preserved or cut away, and then uniting the vagina by sutures to its old attachments. In this and the other operations to be described, the author insists upon thorough *exsection* of the vaginal wall, holding that mere denudation of mucous membrane is of no avail in the attempt to repair the injury.

In cases of "detachment of the vagina above the levatoric plane," an exsection of a triangular portion of the posterior vaginal wall, with the base of the triangle at the cervix and the apex at the levatoric attachment, is advised. The edges of the wound are then brought together by sutures in a nearly transverse line. This is designed to restore the old attachments to the sacral fascia and to the cervix, and also to lift the vagina after removing the redundant slack of its wall. The anterior vaginal wall is to be restored to its normal condition by pulling down the cervix, dissecting up a vaginal flap from its anterior wall, lifting this up until the cystocele disappears, and then, with the finger crowding up the vaginal wall and keeping the bladder out of the way by pressing between the cervix and the vaginal flap while the former is drawn firmly downwards, the vagina is tacked to the cervix by a stitch or two, the redundant part of the flap is cut away, and the wound closed.

This restores the vagina to its normal position and attachments, and it once more acts as a uterine support. As to the technique of the operations, the author uses a sharp-pointed curved scissors, which is made to snip its way between the rectal and the vaginal walls, after it has been entered through a small incision. Thus a flap of the desired shape and size is made of the vaginal wall, and this is subsequently excised. By this method the dissection is bloodlessly, rapidly, and completely made, rendering the necessity for a skilled assistant for sponging but slight.—*Am. Four. Obstet.*, May, 1889.

[The dictum that the attachment to the cervix of the walls of the vagina is that of the uterus to its chief support in the pelvis is hardly sustained by facts. Unquestionably the strong elastic pelvic diaphragm, formed by the anterior vaginal wall in front and the utero-sacral ligaments behind, through which the cervix passes, is an important, if not indispensable, support of the uterus; but this is made a sustaining support by the utero-sacral ligaments to as great, if not a greater, extent than the vaginal wall. The uterus may not prolapse, when, in a cadaver, its ligaments are cut away; but it will also remain in place if

the vaginal walls be cut away from the cervix. If the author of the article has ever performed vaginal hysterectomy, he may have noticed that just as much force is required in drawing down the uterus after it has been completely separated from its vaginal attachments as before the operation had been begun; and then he must have noted the fact that vaginal prolapse precedes that of the uterus in cases of injury to the pelvic floor and of subinvolution after parturition. The intrinsic ligaments of the uterus are by no means mere guy ropes, but are fully competent to sustain a uterus which is normal in size, and which is not subjected to the drag exerted by a prolapsed vagina. The vagina—even its tense closely attached anterior wall—is at best only a supplementary support, and the function of its posterior wall can only, when considered as a support, be that of a secondary supplement—simply an obstruction to the prolapse of the bladder and anterior vaginal wall. If the vaginal walls, normally attached, are the chief support of the uterus, they must act at a most terrible disadvantage, as the axes of the uterus and of the vagina meet at an acute angle, and when marked prolapsus uteri occurs it is preceded by retroversion, which allows the uterus to actually telescope its supporting vagina, even when no faulty invagination of the cervix can be found. Pessaries which support the uterus act by supporting the vaginal walls which have pulled down the uterus, and the theory that an appliance which draws away the posterior vaginal wall from the cervix is sometimes the agent by which that wall is reunited to the cervix from which it had been torn, is certainly less plausible than the one which explains the fact that pessaries sometimes cure prolapse of the uterus by affording the ligaments of that organ to regain their tone by relieving them of the weight of a flabby, prolapsed vagina. *Post hoc, ergo propter hoc* is a tricksy argument, showing a golden side to one and a silver surface to another knight, and even proving to be only a piece of painted wood after the two have debated awhile with their lances; and because laceration of the pelvic floor is followed by prolapsus uteri, the fact is not at all a proof that the perineal muscles are the essential parts of the apparatus which sustains the uterus. Remove the vagina and the uterus will remain in place, unless some unusual force presses it downwards and stretches its ligaments. Separate the pelvic attachments of the vagina, and it will *drag* the uterus down, not *allow* it to fall. The vaginal support to the uterus is only a negative one, if we ignore the utero-sacral ligaments, and any procedure which removes the traction exerted by a loose vaginal wall on the suspensory ligaments of the uterus will correct the dislocation of that organ, if those ligaments have not been stretched to an inordinate degree. Restoration of the normal attachment of the perineal muscles prevents vaginal prolapse; vaginal prolapse means that of the uterus; but the first premise does not mean that restoration of the perinæum gives support to the uterus. As in the celebrated case of determination of the sex of a pseudo-hermaphrodite, the judge must rule that the syllogism by which the question was to be decided—all human beings are either male or female, etc.—was defective on account of the logical error in its structure presented by the "ambiguous middle," which stultified the conclusion to be drawn from its premises.

J. S. H.

So-called Varicocele in the Female.—Dr. A. P. Dudley and H. C. Coe have discussed this subject from opposite points of view, the former having published a paper on the subject with the histories of four cases successfully treated by removal of the dilated veins of the broad ligament by laparotomy. (*N. Y. Med. Jour.*, Aug. 11 and 18, 1888.) The patients had passed the menopause, and suffered from pain about the ureters, running up to the region of the kidneys, and present while the patient was in the erect posture. After lying down the pain was relieved. Examination in the semi-erect position by the rectum revealed a knotted, convoluted mass, in the broad ligaments, which was similar in feel to a varicocele of the spermatic cord. In the recumbent position this peculiar mass is felt as a thickening of the ligament. The symptoms, and the nervous condition caused by them, promptly and (thus far) permanently disappeared after removal of the dilated and thickened veins which were found in the broad ligaments when laparotomy was performed. These veins were examined by Dr. W. H. Porter, who found in them the changes of structure commonly present in varicocele veins. Dr. Dudley concludes from his experience that

this condition can be regarded as a true varicocele of the broad ligament; that it is not an uncommon affection; that it can be diagnosticated with comparative ease by the peculiar pain which is present when the patient has been upon her feet for a short time, but which disappears after she has lain upon her back for a few minutes, and by the recognition of a knotted mass of cord-like veins on rectal examination in the semi-erect position; that the condition is productive of a degree of suffering which justifies removal of the veins by laparotomy, even after the menopause, as this has given complete relief, and that many cases of "chronic cellulitis" are actually of this character, and incapable of relief by ordinary local or medicinal treatment. The operation is indicated in certain cases in which the diagnosis has been made and treatment has failed to relieve.

Dr. Coe, (*Am. Jour. Obstet.*, May, 1889). denies the analogy of this condition to varicocele in the male; questions the possibility of accurate diagnosis; considers the condition uncommon, as it is not often found at autopsies; doubts the non-efficacy of counter-irritation and tamponning in the vast majority of cases, the justifiability of the operation, which involves the "quilting" of the broad ligaments—so apt to result in secondary hemorrhage—after the menopause has been passed.

A large portion of each paper is taken up by discussion of the propriety of the nomenclature adopted by Dr. Dudley—"Varicocele in the Female,"—and of the analogy between dilatation and thickening of the veins of the broad ligament and varicocele in the male. Anatomy, ætiology, and symptomatology of both conditions are discussed; but the important and only practical questions to be decided are: Is this condition one which may be regarded erroneously as inflammatory induration, and non-curable by the simpler methods of treatment? Is the diagnosis an easy matter? Is laparotomy, as performed by Dr. Dudley, indicated by the severity of the symptoms, or the hopelessness of affording relief by other means after the menopause has occurred? The operation has been uniformly successful in every way, and as the number of cases is so small, no fair conclusions can as yet be drawn. The great danger lies in the improper employment of what has been proved feasible and effective.

THERAPEUTICS.

Titus (J. S.) on Sulphonal.—The cases in which this author has used sulphonal have been mental:

1. A male of forty-six—chronic mania with periods of unusual excitement, nervous irritability, and most annoying sleeplessness—slept naturally seven hours after a dose of thirty grains, and awoke refreshed and not needing restraint.

2. A man of twenty-six, with recurrent mania, furious and violent in all his acts, was given thirty grains of sulphonal, which in his case it was necessary to repeat in an hour. An hour after he was sleeping in a restless, broken manner, for five hours, got up, ate his breakfast, returned to bed, and slept the entire day and night; the next day was quiet, tractable, and materially improved, required, no more sleeping mixtures, kept improving, and in three weeks discharged cured.

3. A man of thirty, acute mania, was noisy, praying, singing, preaching, imitating actors, violent to the inmates of the ward, injuring one severely before he could be properly restrained, and was very sleepless. Thirty grains sulphonal put him before an hour in an apparently natural sleep, lasting from 9 P.M. to 7 A.M., awoke refreshed, free of excitement, required no medicines afterward to induce sleep, continued to improve generally, and in two weeks discharged cured.

In the first two instances the sulphonal was preceded by a dose of combined chloral, bromides, and hyoscyamus, with a good result. In the third case it had no effect.—*Med. Standard*, June, 1889.

Kavanaugh (C. W.). Observations on Sulphonal. — The author reports three cases in which sulphonal was successfully employed, morphine having been habitually used by all.

A man of 30 with enteralgia, a man of 40 with severe headache from alcoholic excess, and a woman of 35 who suffered from periodical bilious headaches. His experience seems to show that sulphonal has some effect even during abstinence from morphine. He thinks it gives more relief in rheumatism than antipyrin.—*Med. News*, July 6, 1889.

Penny (E. W.) on Antifebrin.—Dr. A. L. Saylor reports a case within his experience in which he gave to a child four years of age, with a temperature of 101° to

103°, four grains of antifebrin. An hour afterwards alarming symptoms of collapse set in with a subnormal temperature. The patient was, however, revived by means of restoratives and recovered.

I can report a similar case in that of a girl 15 years of age in the second week of typhoid fever. The temperature having risen above 104°, I gave five grains of antifebrin and left two more five-grain powders to be administered an hour apart, my intention being to return before the third was taken, to observe the effect. Soon after the second dose had been taken I was summoned by a messenger, who said the girl was dying. I found the patient very weak, with cold extremities, a fluttering pulse, and a subnormal temperature. Hypodermics of brandy soon revived her, and without any more antipyresis she subsequently recovered from her illness.—*Times and Register*, June 22, 1889.

Hackett (N. P.) on Cocaine in Hemorrhagic Fever.—In a bad case of malarial hemorrhagic fever where the stomach was too irritable to retain any medicine, the author, after exhausting all reputed drugs for the purpose, allayed the stomach with cocaine, two $\frac{1}{10}$-grain doses, and then was able to give calomel and soda, quinine to prevent another chill, and bitartrate of potash as a diuretic, with the great satisfaction of seeing them all retained.—*Med. Register*, Feb. 16, 1889.

Day (R. H.) on Salol in Typhoid Fever.[1]—The author gives five grains of salol every three hours in typhoid fever, and almost no other medicine, with what he claims to be the best results. He does not attempt to explain its mode of action, and would by no means restrict its application to the treatment of typhoid fever, for he has repeatedly given it in the diarrhœas and dysenteries of infants and children with the best results, and in an adult white male, attacked with *ilieitis*, having frequent and copious bloody watery stools, fever and great pain, prostration and soreness over the bowels, he used salol 5 gr. with pulv. ext. opii ½ gr. every two to four hours with prompt relief, and an established convalescence in forty-eight hours.

Judging, then, from his short experience, the drug appears to be suitable and useful in inflammations of the mucous coat, glands, and follicles of the intestinal tract, upon which it appears to exert a prompt and peculiar beneficial influence.

In a later article, entitled "Priority in the Use of Salol,[2] the author justly complains that his investigations have been overlooked in the hurry to get "the latest" from Europe. He says: "Had my experience emanated in *Germany* or *France*, or any other *foreign country*—and been heralded by the name of some Professor, I trow, that our medical journals would not have been slow in publishing the information—and making it known to all of our reading physicians.

"Mr. Editor, can you tell how, or, why it is that the labors and work and experience of our country physicians are thus ignored by our journals?

"Why not encourage and stimulate their labors in the field of medicine, that their good works may be known and recognized; and they, if meritorious, receive the distinctions and the honors accorded to metropolitan professors and physicians?

"The great mass of physicians all over this wide country, must be educated, stimulated, and worked up to the high standard of the present requirements of medicine, if we would make our profession in this country as in Europe, useful, respected, and influential. This I conceive to be the duty of our journals—what say you?"

Sears (G. G.) on Four Cases of Phthisis Treated by Inhalations of Hot Air.—The author says:

"Conclusions drawn from so small a number of cases are apt to be untrustworthy, but in these instances the following summary seems justifiable:

"1. Cases so treated differed but little in their course from those treated by the older methods. Whatever gain was noticed seemed more justly attributed to the expansion of the lungs from forced inspirations than to any effect of the hot air *per se*.

"2. Little influence can be expected from it upon the development of the bacilli. Any germicidal action it may have is largely exerted in sterilizing the bronchial secretion, and is to be looked upon rather as a prophylactic measure against the spread of the disease than as curative in any particular case.

"3. While it is not proven that the occurrence of hemorrhage in these cases was not all dependent upon the form of treat-

[1] *Jour. Am. Med. Ass'n*, Jan. 26, 1889.

[2] Daniels' *Texas Med. Jour.*, April, 1889.

ment, theoretical considerations make it probable that it increases the tendency thereto, and suggest caution in its use.

"In one case the inhalations were omitted after a week, owing to salivation and soreness of the mouth, with a loss to the patient of three pounds in weight. This loss simply emphasized the general tenor of the case, as it was afterwards partly regained and was fairly attributable to mental disturbance, as she expressed great anxiety at the possible effects of such unusual therapeutics.

"In one case temporary improvement was quite marked, but at the time the treatment was discontinued there had been a further advance of the disease, and for the first time in the history of her illness hæmoptysis occurred. In another case the improvement in general condition, which had commenced before treatment, continued without a corresponding improvement of physical signs. The patient died from hemorrhage. Another case under treatment developed blood in the sputum for the first time. The temperature in about all was unaffected, in one it was elevated."—*Boston Med. and Surg. Jour.*, July 11, 1889.

Jacobi (A.) on the Baking of Bacilli.—The author denounces Weigert's advertising scheme, and reviews his own experience with the inhalation of hot air in the treatment of phthisis. Weigert, supposed to be an American physician, now of Germany, claimed to have discovered a method of curing phthisis by the inhalation of hot air, and he had made free use of Dr. Jacobi's name in advertising his apparatus for carrying out this treatment. The treatment was not original with Weigert, nor had Dr. Jacobi, as had been asserted, bought, endorsed, or recommended the apparatus in question. Moreover, as appeared further along, he had little confidence in the method. To Halter belonged the honor of suggesting the treatment of phthisis by the inhalation of hot air with the view of killing the bacilli in the lungs. The idea arose from observing the immunity from phthisis of workmen in a lime-kiln where they were exposed to a high degree of heat, 122° to 158° F., so high that it would destroy the tubercle bacilli provided it continued at that degree until it had reached the lungs. The air inhaled by workmen in a lime-kiln was dry and rarefied. A moist atmosphere of a like temperature would be more destructive of the bacilli, but was less endurable by the phthisical patient. Dr. Jacobi said, that having been requested to admit Weigert's apparatus into his wards at Bellevue Hospital, he did experiment with it some time ago, and for a while the results made a favorable impression on the physicians in attendance, for the patients, or a part of them, seemed to improve under the treatment. More careful observation, however, showed that the improvement was doubtless due to rest in the hospital, in an atmosphere much purer than that in which the patients had lived in their tenement homes. The instrument itself was not as good as that which one of ordinary ingenuity could improvise; the atmosphere on its way to the lungs from the flame was found to have fallen from above 300° F. to about the temperature of the body when it had reached the mouth. Of course if it were above the temperature of the blood it would become further cooled on its passage toward the lungs. Some of the hot air might get into the alveoli, but very little. In order to obtain benefit from such treatment it would be necessary not only that the air inhaled be of a high temperature, but that the patient be in a room in which the thermometer registered at least 105.5° F. In other words, it would be necessary to produce a sort of artificial fever, and it was evident that such treatment must prove injurious to any other than patients in the very first stage of phthisis. He added that two of his patients suffered from cough and vomiting during the treatment with hot air, and were distinctly better when it was discontinued.—*Med. Record*, July 13, 1889.

McCaskey (G. W.) on the Inhibitory Action of Antiseptics.—According to the author, solutions of antiseptics one fifteenth as strong as those required to kill a given germ (its lethal dose) will render it functionally inactive, and consequently harmless, in wounds during the continued action of the antiseptic, and for a variable time thereafter. This should be called its inhibitive dose.

In solutions materially weaker than one fifteenth the lethal dose bacteria will flourish, to all appearance, quite as well as though no antiseptic were present.

The inhibitive doses of the various antiseptics should be as actually determined and as widely known as are their lethal

doses, and should be studied with special reference to the different species of pathogenic and putrefactive organisms.

If wounds were irrigated, either continuously or at brief intervals, with inhibitive doses of antiseptics, surface bacteria could not manufacture ptomaïnes, the chief or only cause of morbid wound processes. Fresh infection of the wound would also be impossible.

A sufficient quantity of antiseptics to render the blood inhibitive in its effect upon any organisms which it might contain cannot at present be introduced into it.

The beneficial effects following the administration of antiseptics in dysentery, typhoid fever, and other diseases of that type, are probably due to the direct action upon the germs of the antiseptics before their absorption.—*N. Y. Med. Record*, July 13, 1889.

Schapps (J. C.) on the Preparation of Cat-Gut.—The author immerses his cat-gut in ether contained in a wide-mouthed, glass-stoppered bottle, changing the ether frequently until it becomes perfectly clear. The cat-gut becomes white, and has a clean feel. Fatty and other organic matters are dissolved out, and the gut is aseptic. The author has never seen a drop of pus follow its use.—*Med. Record*, July 13, 1889.

Gregory (C. L.) on Cactus Grandi Florus.—The author claims that the tincture or fluid extract must be made from very recently gathered plant, or it is worthless. He finds it very useful in organic and functional heart-disease. His reported cases are:

1. Male of thirty-eight, subject to rheumatism. Troubled for five years by dyspnœa and palpitation. Double mitral murmur. Treatment: Four-drop doses of strong tincture of cactus and pepsin four times a day. Great improvement in three months, and completely capable of attending to his business all day on his feet.

2. Male of fifty-six. General anasarca from mitral insufficiency. Orthopnœa, intermittent, feeble, irregular pulse, and vomiting every five or six hours. Treatment: Eight-drop doses of cactus after vomiting spells, with ten-drop doses of tincture of apocynum cannabinum for the anarsarca. Much improvement.

3. An adult male, with functional heart-trouble following malarial fever. Pulse intermittent and feeble, and patient alarmed nervous, restless, sleepless, and apprehensive. Complete relief from cactus and other remedies for indigestion.—*Med. Register*, April 30, 1889.

Atkinson (J. E.) on Some of the Rarer and Graver Forms of Cinchonism.—The writer has collected more than fifty recorded cases of quinine amaurosis, and showed that impairment of vision is probably much more often produced in this manner than is generally believed. Usually blindness only follows excessive doses, but definite results cannot always be attributed to definite doses, and blindness has been known to follow as small a dose as twelve grains. It may develop slowly or, as is usual, suddenly. The duration of total blindness may be from a few hours to many weeks. It is never permanent. Perfect vision, however, is never recovered. Careful observation has shown that the symptoms are characteristic and pretty constant. They are: 1. Transitory blindness, complete or incomplete. 2. Color-blindness. The color-sense usually is restored ultimately. 3. Wide dilatation of the pupil, which is irresponsive to light. 4. Pallor of the optic disks, and extreme diminution of the retinal vessels. 5. Contraction of the visual field. This never entirely disappears. Impairment of hearing with tinnitus is almost always present, but rarely lasts more than twenty-four hours. A number of variations from the type are noted. Idiosyncrasy undoubtedly plays an important part in the development of these symptoms. The pathogenesis of quinine amaurosis is not understood. The effect is probably a local one exerted upon the blood-vessels of the part. The dose competent to produce blindness varies greatly. Though blindness probably always results when the dose has been lethal, as much as one ounce failing to produce general poisoning has been known not to affect vision. In a number of cases patients have become blind after thirty to sixty grains given within a few hours.

Complete permanent deafness has never been known to follow the use of quinine, and permanent impairment of hearing from the same cause is very uncommon, not so uncommon, however, as is generally supposed. Roosa, Burnett, Greene and others have given abundant reasons for their belief that permanent partial deafness may occur. In these cases, however, a decided

hyperæmia of the auditory apparatus is produced.

General poisoning from cinchona preparations is rarely fatal. Baldion reported a death from 20 grains to a child six years old given in forty-eight hours. Deaths have also followed the administration of 100 grains given in two days, and of 120 grains in doses of 5 grains repeated every hour. A number of cases of alarming symptoms following not excessively large doses are given. In more severe cases the patient's condition may border upon collapse. There will be extreme prostration, with or without loss of consciousness, or coma, lowered temperature, gradual weakening of the pulse and respiration, chilling of the entire surface, copious cold sweats, deafness, dilatation and immobility of the pupils, blindness, lividity. Convulsions have been reported in a goodly number of cases. The exact nature of these convulsions has not been determined. Experiments upon animals by various observers show that quinine has a special convulsivant action. Brunton has also shown that convulsions may precede death as a result of asphyxia.—*Med. News*, June 29, 1889.

MEDICINE AND PATHOLOGY.

Henry (F. P.) on Aneurism of First Portion of the Arch of the Aorta, Communicating with the Pulmonary Artery.—When I took charge of the case, Feb. 1st, the principal symptoms were dyspnœa and pain in the chest and dorsal region of the spine. There was great œdema of lower limbs and scrotum, and considerable ascites. There was well-marked dulness in the left infraclavicular region, and in the second left intercostal space pulsation could be plainly felt. In the same region a distinct thrill was present, and was so marked as to be easily felt through the patient's underclothing and night-shirt. There was no perceptible inequality of the radial pulses. Neither pupil was contracted, and at no time had there been flushing of either side of the face. There was no dysphagia, and, although there was a certain amount of cough, it was not of the violent, paroxysmal form caused by irritation of the recurrent laryngeal nerve.

The aneurism was shown on autopsy to occupy the right sinus of Valsalva, and communicated with the pulmonary artery by an oval aperture, of which the long diameter measured about one fourth inch. The opening was exactly at the point of attachment of a pulmonary leaflet, which was, therefore, almost entirely destroyed.

There was another small aneurism about the size of a walnut in the descending portion of the arch. Its posterior wall had been torn away in the dissection. This small tumor had eroded the body of one of the vertebræ. Some years ago this man had a popliteal aneurism which was cured by ligature of the femoral.

In an excellent article on Aneurism in the Medico-Chirurgical Transactions for the year 1840, Mr. Thurman designated cases of aneurism of the ascending portion of the arch which communicate with the superior vena cava, the right auricle, the right ventricle, or the pulmonary artery, in one word, with the venous side of the circulation, as "spontaneous varicose aneurism." He reports fourteen such cases, in five of which the communication was with the pulmonary artery. These cases are Nos. IX. to XII. inclusive, on the list.

In case IX. death was from gradual failure of the circulation, and there were three communications between the aneurismal sac and the pulmonary artery. It is altogether beyond the bounds of probability that three openings into the pulmonary artery should have formed simultaneously.

In case X. death occurred in about twelve hours after the probable time of formation of the opening, which was single.

In case XI. the perforation, which was in the left branch of the pulmonary artery, occupied the exact side of the ductus arteriosus. The patient died shortly after admission, and there was no clinical history. This may have been a case of patulous duct complicated with aneurism.

In case XII. death suddenly occurred at the probable time of perforation.

A case is reported by J. Hughes Bennett, in which the perforation must have occurred some time before death, as there was no sudden change either in the physical signs or symptoms, the patient gradually sinking from progressive failure of the circulation.

In a case reported by Smith,[1] the edges of the opening were thickened and rounded off, and the communication between the two sides of the circulation must have existed from Christmas until the following April.

Wade[2] reports a case in which the opening into the pulmonary artery probably occurred eight weeks before death.

Œdema, more or less general, appears to be a constant symptom of spontaneous varicose aneurism, and, according to Thurnam, diagnostic indications concerning the point of venous perforation may be derived from its extent and situation. When the communication is between the descending aorta and the inferior vena cava, the dropsy is limited to the lower half of the body; when between the ascending aorta and the superior vena cava, it is most marked in, or limited to, the arms, face, and upper half of the trunk; when between the ascending aorta and one of the right or left cavities of the heart, or the pulmonary artery, it is universal. In the present instance the œdema was universal, and was most marked in the left upper extremity, the skin of which was also latterly the seat of an acute, diffused erythema.

In this form of varicose aneurism the blood is propelled into the pulmonary artery both during systole and diastole, and, therefore, there are two murmurs, or, as in the case I am reporting, one prolonged, rasping murmur. I know of but one instance in which the diagnosis of this condition was accurately made, and this was the case of Dr. Wade, of Birmingham, England, already quoted. According to Wade, the key to the diagnosis of this form of varicose aneurism, is the non-conduction of the second murmur to the apex of the heart. We should, therefore, he says, be at a loss, 1, when aortic regurgitation existed; 2, when pulmonary regurgitation existed; 3, if varix produced no murmur with the second sound; 4, when there was also an opening into either ventricle, or into the left auricle or its appendix.

In the present case, no hissing sound was ever heard, the murmur as already stated being systolic, loud, rasping, and heard with greatest intensity to the left of the sternum, in the second intercostal space, where also a well-marked thrill could be felt. Both the signs and symptoms seem to me to indicate that this aperture of communication between the aneurismal sac and the pulmonary artery is of long standing. A microscopic examination of the edge of the aperture might perhaps throw some light on this question.—*University Med. Mag.*, July, 1889.

Gairdner (W. T.). on a Case of Aneurism of the Arch, Perforating into the Vena Cava Superior.[3]—The aneurism occupied chiefly the transverse portion of the arch, which was generally dilated, but with two more localized dilatations, one extending to the right, the other to the left. The first of these compressed the vena cava superior, and was adherent to it, forming a round bulging into the interior of the vein, corresponding with the middle and upper third of this vessel. On the summit of the bulging there was a rounded aperture of communication, a quarter of an inch in diameter, and an inch and three quarters beneath the origin of the innominate vein. The abdominal appearances were of no importance.

A laborer, aged forty-four, was admitted to the Western Infirmary on January 13, 1888. He died on January 21st, and the treatment, consisting of absolute rest in bed (as nearly as possible), with repeated doses of tincture of veratrum viride, did not seem to make any appreciable change in his condition or in the rate of the heart's action, which was unduly rapid throughout. The symptoms were very marked cyanosis, with general anasarcous swelling of the upper part of the body, extending secondarily down the back as far as the sacrum, but not at any time affecting the lower extremities. These symptoms were attributed to a common cold caught a week before admission; but on close questioning he admitted having been conscious for two years of a slight degree of pulsation referred to the right sterno-clavicular region and its neighborhood, which did not, however, give him any concern. The first occurrence of swelling was accompanied by a feeling as if "something had given way" in the left side, this sensation being referred to a point rather to the left of the cardiac apex. He had no feeling of pain at this time, but of something like faintness and of a cold sweat. This continued for about ten minutes, and never recurred. Swelling of the

[1] *Dublin Medical Journal*, vol. xviii.
[2] *Brit. Med. Journal*, July 6, 1861.
[3] See MEDICAL ANALECTIC, July 4, 1889, p. 322.

face and right arm followed, but had considerably diminished in degree before admission. There was some prominence of veins in the lower sternal, precordial, right hypochondriac regions, and in the hands, more marked on the left side. There was a very loud and characteristic murmur all over the front of the chest, loudest in the region of the double aortic murmur. Pulse was stronger in the right wrist, 108 to 110, unaffected by the veratrum viride. Pupils large, mobile, and equal. Cardiac dulness was displaced downwards and to the left, and the entire manubrium sterni was dull. There was an appreciable jugular pulsation. Although cyanotic he had little cough or dyspnœa. Death was apparently due to the failure of respiratory reflexes.—*Lancet*, June 22, 1889.

Welch (W. H.) on External Sources of Infection in Relation to Preventive Medicine.—The air is a common medium for the transportation of infectious agents, but the danger from this source has been overestimated. Unlike the soil, the air does not form a resting- or breeding-place for bacteria. Bacteria may adhere to particles of dust, but they do not exist to any great extent in the air in single detached particles. The air bacteria are derived from the ground, and in order to be taken up by the air they must first become dry. This fact is of great significance in the application of measures for the prevention of infection through this channel. The indications which it suggests are the necessity of guarding against the desiccation, when exposed to the air, of substances which contain infectious germs not destroyed by drying and free ventilation.

A most important source of external infection is the ground. Unlike the air, the ground is the resting- or breeding-place of numerous forms of micro-organisms, some of which are pathogenic. It is in the superficial layers of the soil that bacteria flourish. Among the pathogenic micro-organisms which find their habitat in the ground, are the bacilli of malignant œdema and of tetanus. In favorable situations the bacillus of typhoid fever, of anthrax, and of cholera, may have their abiding-place there, and, under suitable conditions, multiplication of these germs may take place. The tubercle bacilli may also preserve their vitality in the soil for a long period under specially favorable conditions. The soil, however, is not a favorable breeding-place for most of the infectious bacteria.

Bacteria derived from the soil may be introduced into the body, conveyed on currents of air, only when the surface is dry. They may also be conveyed by means of vegetables, by the intervention of domestic animals, by the medium of flies and other insects, and in various other ways. The most important medium, however, is drinking-water, which becomes charged in various ways with these morbific agents.

In preventing infection, directly or indirectly, from the ground, it is of first importance to prevent the pollution of the soil by infectious substances. One means to this end is the adoption of a perfect system of drainage, whereby substances which favor the existence of infectious germs are kept out of the ground. Another means is thorough cleanliness about habitations. In cities, the proper paving of the streets, absence of unnecessary disturbance of the soil, cleanliness of streets and spaces, and the laying of dust by sprinkling, are important in preventing infection from the ground and dust.

Another vehicle of infection is water. Bacteria abound in water, and even pathological bacteria may preserve their vitality for a length of time in this medium, if they do not actually multiply. So far as our knowledge goes, drinking-water is not a favorable breeding-place for pathological micro-organisms. Still, there is no reason for rejecting the belief that both cholera and typhoid fever are conveyed by this medium. Infection from water is to be prevented by avoiding water suspected of infection. When this is not possible, the suspected water should be boiled. The only means of purification of surface water on a large scale is filtration. Domestic filtration is unsatisfactory, but filtration of the general supply, by means of large sand-filters, furnishes excellent results.

Still another medium of infection is our food. Many articles of food form excellent nutritive media for the growth of pathogenic micro-organisms. Infection of food may be derived from deposits of dust, from earth, from water used in its preparation, and from contact in various other forms with infection. Milk is particularly liable to convey infection. There may be produced in it, as well as in other forms of food, by bacteria incapable of multiplying in the body, certain organic alkaloids, the

so-called ptomaines, which produce poisoning and render the alimentary membrane more susceptible to infection by morbific organisms.

Articles of food may be primarily infected. For example, the milk from tuberculous cows and the flesh of animals infected with parasites. The measures of prevention are obvious. The cooking of food immediately before its use, the boiling of milk when the supply cannot be carefully controlled, and the application of efficient sanitary inspection of all food supplies, form the basis of preventive measures.—Editorial, *Med. News*, July 13, 1889.

Maus (L. M.) on Corporal Disinfection in Scarlet-Fever as a Preventive Measure to its Spread.—The author advises as follows:

1. Sponge the patient thoroughly morning and evening with a tepid solution of corrosive sublimate, 4 to 1,000, as soon as the eruption makes its appearance.

2. Wash the hair once daily with a solution of the corrosive sublimate, of the same strength, and also a solution of borax, 1 to 250.

3. Disinfect the urine, fæces, and expectoration, also the discharge from the ears and nose, if there be any. A solution of the bichloride, 1 to 1,000 is best for this purpose.

4. As soon as the patient is permitted to leave the bed have the body washed with warm water and soap, then sponged with the 1 to 4,000 bichloride solution, wiped dry, and anointed with the following ointment:

℞. Sodii biboratis,
Zinci oxidi.....āā ʒ iv.
Ol. gaultheriæ..... ʒ ss.
Vaseline..... ʒ iv.

The hair should be thoroughly washed with the bichloride and borax solution.

5. The patient is then to be enveloped in fresh and clean clothes throughout, and allowed to leave the sick-room if his condition otherwise admits of it.

6. The bed linen, soiled clothes, towels, etc., should be placed in a suitable sublimate solution and boiled, and the room well disinfected with sulphur. The sulphur candles are very convenient, and the disinfection should be repeated the second day, as the germs are very tenacious of life.

7. Require the nurse or attendant to keep the hair, face, and hands well disinfected during attendance, and to likewise make a complete change in his or her garments on date of the disinfection of the sick-room.

8. Continue the provisions of the third and fourth rules once daily until desquamation is complete.

The above method for the prevention of scarlet-fever has proven very efficacious in my hands, and, though simple, warrants a fair trial by the profession. I think there need be no fear of corrosive sublimate poisoning, as a very minute quantity of the drug is liable to enter the system by this means. Other germicides may be used in place of the mercury, and it is probable that other eruptive diseases may likewise be treated with success in a similar manner.—*Med. Record*, June 22, 1889.

Kitasato on Pure Cultures of Nicolaïer's Tetanic Bacillus.—The first description of the bacillus of tetanus is due to Nicolaïer; it has been found in the ground, in the tetanic man, and pure cultures of this bacillus have never been obtained until now. A young soldier died from tetanus; in the pus obtained from his wound the bacillus of Nicolaïer was found. The inoculation of this pus in mice determined the appearance of true tetanus, and in those animals the characteristic bacillus has been discovered; but the cultures always failed, and only mixed cultures could be obtained. Studying these more closely, he found, beside Nicolaïer's bacillus, three species of facultative anaërobic microbes and seven species of facultative aërobic microbes, but none of them could produce tetanus. The tetanic bacillus is a true anaërobic bacillus. After having seen that the mixed culture obtained with the tetanic bacillus contains the greatest number of Nicolaïer's bacilli when it is maintained at a temperature of 97° F., he subjected it for some time to this temperature, and the culture being then in full development, he placed it in a water bath at 176° F. This temperature kills all adventitious microbes, but allows the tetanic bacillus spore to live. After this partial sterilization, the plate culture is maintained at a temperature of 64° to 70° F., in an atmosphere of hydrogen. In this manner he succeeded in obtaining a pure culture of Nicolaïer's bacillus, with which he was enabled to produce tetanus in rats, guinea-pigs, and mice. The tetanus always propagates itself from the point of inocula-

tion ; the regions surrounding this point are always first affected. Nicolaïer's bacillus resists heat very well, and must be exposed for five minutes to a temperature of 212° F. to be killed. A five per cent. solution of carbolic acid does not destroy this bacillus in ten minutes. The most curious fact, however, is, that the bacilli disappear very rapidly in the blood ; they apparently produce ptomaines, but this remains to be demonstrated. — *Med. News*, June 22, 1889.

Bacteriology of the Umbilical Cord.—The umbilical cord at birth is entirely free from bacteria ; all which may be found in the stump later on come from external sources. The non-pathogenic germs which develop on the stump are *Sarcina lutea* and *Bacillus subtilis :* the pathogenic *Staphylococcus albus*, *S. aureus*, *S. citreus*, and *Streptococcus pyogenes*. According to its surroundings, the stump either mortifies or mummifies. Moist gangrene favors the development of pathogenic and non-pathogenic germs. In mummification, pathogenic germs only develop in very small quantities. Gypsum powder was found the best protective against germs, and the most perfect mummifier or desiccant. The pathogenic bacteria of the cord are identical with those seen in puerperal affections, yet are absolutely independent of such complications in the mother, and of gonorrhœal ophthalmia in the infant.—*Br. Med. Jour.*, June 22, 1889.

Musser (J. H.) on Some Clinical Aspects of Vomiting.—Regarding the relation of this symptom to cerebral hemorrhage the following conclusions were presented :

1st. That constant vomiting in the aged, painless, with or without nausea, with no evidence of indigestion or acute gastritis, the ejection composed of mucus or a watery fluid, was often one of the first symptoms of central hemorrhage.

2d. Such vomiting was not attended with the usual symptoms of relaxation and with the sthenic phenomena which usually attended apoplexy.

3d. If the usual collapse symptoms occurred in a person of that age, the vomiting was more likely to be due to a uræmic origin.

4th. If the respiration was altered in rhythm, or was of normal frequency or hurried, because of the intimate relation of the centre of vomiting and the pneumogastric centre, the cause was doubtless a central hemorrhage. Hurried breathing attended the acute vomiting of other causes.

5th. The occurrence of vertigo was not of special significance.

6th. The prognosis was very grave in such cases.—*Boston Med. and Surg. Jour.*, July 4, 1889.

Cure of Exophthalmic Goitre.—At a meeting of the Gesellschaft der Aerzte in Zurich, held in February, Dr. Hermann Mueller showed a girl, aged ten and a half, cured of acute exophthalmic goitre. About a fortnight before the girl came under notice there had suddenly appeared, without any visible cause, an extreme awkwardness in the movements of the child's hands, so that she had become unable to write or to perform any manual work. Shortly afterwards frequent vomiting, general lassitude, vague pains all over the body, exophthalmos, and, ultimately, marked swelling of the thyroid gland had supervened. There was also increased action of the heart, with moderate enlargement of the area of cardiac dulness, systolic *bruit*, and tachycardia ; there was a loud systolic murmur over the goitre. The treatment consisted in local inunctions of iodine ointment, with steel and arsenic internally. In about six weeks every trace of the disease disappeared, and the cure was apparently permanent. —*Br. Med. Jour.*, June 22, 1889.

An Accessory Thyroid Gland.—At the recent Congress of German Surgeons, Dr. Rudolf Wolf, of Hamburg, related a case of accessory thyroid gland, of which he said there was no similar example on record. The patient was a girl, aged 18, who from her twelfth year had complained of a sensation as of a foreign body in the throat. On examination Dr. Wolf found a tumor at the base of the tongue, extending from the left side to the middle of that organ ; it was hard and solid to the touch, and was clearly marked off from the tongue-substance by its color. Treatment by iodide of potassium internally, and local applications of iodine at first produced some effect, but the tumor soon began to grow, and attained such a size that swallowing became difficult. Dr. Wolf then removed it, first performing tracheotomy, and next detaching the tongue from the mucous membrane of the mouth and dividing the arch of the fauces on the left side. The patient made a rapid recovery. —*Br. Med. Jour.*, June 15, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON M.D.

With the active collaboration of

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OCCASIONAL REPORT ON OBSTETRICS.

Hirst (Barton Cooke) on Non-Infectious Fevers in the Puerperal State.—The concentration of attention upon the bacteriological aspects of puerperal disorders has tended to lead the average practitioner to ignore any other than a septic cause for any puerperal elevation of temperature. The author, in a recent paper, would make a plea for the consideration of various forms of pyrexia, where no suspicion of septic infection exists.

Fever, during the lying-in period, not due to infection, may arise from emotional causes, from exposure to cold, from constipation, from reflex irritation of any kind, from cerebral disease, from eclampsia, from insolation, from syphilis, from the exacerbation or persistence of an acute or chronic disease, contracted before or during pregnancy. This grouping excludes all consideration of septic infection, and of the infectious fevers, as the exanthemata, erysipelas, malaria, and pneumonia. A woman may unquestionably acquire any of the acute or chronic fevers during pregnancy, which may persist in the lying-in period, or take on a new activity during that time. The effect of labor upon the course of phthisis has interested many persons. The assertion that the disease makes no progress, or at least is very much retarded after delivery, the author believes unfounded. It is hardly probable that processes which often exhaust a healthy woman should not exert an unfavorable influence upon a wasting disease. The writer adheres to the opinion of Austin Flint, that the anæmia of pregnancy, the drain of the puerperal discharges, and the excretion of so large a quantity of nutritious material during the period of lactation, are often accountable for the origin of phthisis in women with tuberculous tendencies.—*Univ. Med. Mag.*, June, 1889.

Maus (L. Merrin) on Prolonged Gestation in the Human Female.—The writer reports a case occurring in his own practice, as a reliable instance of a very prolonged gestation—one extending over a period of 334 days. "Mrs. M. T., American, white, aged twenty-nine, husband living, was taken sick with her catamenia May 13th, extending over the usual period of four days. Early in June, the following month, she complained of intense nausea, or morning sickness, and distaste for food, with inability to retain it. She also stated that the odor of food being prepared for the table was more pronounced at this time, a symptom almost always present in early insemination. These early developments, together with absence of future menstrual epochs, were sufficient for an opinion of impregnation. I saw Mrs. T. several times during the summer, and was informed by her that she felt motion September 17th, and regularly after the 25th inst. Preparation was made for her expected labor the latter week in February, the proper date fixed by the ordinary methods of calculation. I was called to see her from time to time during the fol-

lowing March, and found her very large, but suffering no special pain. On account of the protraction of pregnancy and her immense size, I fancied that hydramnion might be the cause of her retarded labor, and made preparation to aspirate the amnion, but abandoned the attempt on account of the difficulty of inserting the aspirator. Matters continued, however, unchanged, until April 14th, when she was delivered of a healthy male infant weighing nine pounds, which apparently was not prematurely developed."—*N. Y. Med. Jour.*, May 11, 1889.

Love (I. N.) on Chloroform in Obstetrics.—The author has become convinced that it is the duty of the accoucheur to give his patient the benefit of anæsthesia. In his judgment, chloroform should be administered in every case of labor, natural and unnatural, that will consent to take it. The use of chloroform is advantageous in that it saves the strength and increases the endurance of the patient, and, other things being equal, the patient will more promptly recover her normal condition. By its tranquilizing effects, the tendency to puerperal convulsions is more than likely greatly lessened. With proper care, and the administration of a drachm of fluid extract of ergot immediately upon the expulsion of the head, post-partum hemorrhage is almost completely obviated. The writer thinks that, if this plan be pursued, the perineum is probably less liable to be ruptured, and the child is in no manner unfavorably affected.—*Weekly Med. Rev.*, May 18, 1889.

Bigham (E.) on a Case of Puerperal Peritonitis with Peculiar Heart Manifestations. — The patient was twenty-seven years old, and in her second confinement. When the physician was called, he found the os dilated about two inches, with the parts rigid, and "with an inclined presentation of vertex to the right, with the left parietal protuberance presenting." Version of the vertex was attempted, and with success. The placenta was believed to be adherent, and the physician detached it with hand in the uterus. The usual antiseptic precautions were taken. On the third day general peritonitis developed. The course of the disease was not favorable, and counsel was called in. At the examination at this time, a mitral murmur was detected. Digitalis and strychnine were ordered, and the patient grew no worse. On the ninth day the patient called her husband to her side, said that her heart had "flopped over," and wished the physician summoned. On his arrival he found the pulse 150; in a few hours it had increased to 200, and became almost imperceptible. A few hours later it began to decrease in rapidity, and in eight hours had fallen to 135. As the physician was sitting by the bedside, talking with the patient's husband, she said: "My heart has just snapped, and don't run that way now." The physician immediately put his finger on her pulse and counted it as 78, and strong. After this the pulse remained slow, not again rising above 96. The mitral murmur also disappeared when the patient regained her health.—*Med. Record*, June 1, 1889.

Ball (R. Randolph) on a Singular Case of Multiple Labor and its Management.—The patient was a robust laboring woman of thirty-eight. A year before she had given birth to a healthy child, although delivery had been by forceps. The birth of the first child of this second labor was accomplished by the natural forces, but as the placenta did not follow, and the uterus still remained large, the presence of a second child was suspected. The abdomen was so thickly covered with fat that it was impossible to make out any thing by palpation. On passing the finger up the umbilical cord, which was firmly held above, a peculiar resistance was felt, which seemed to the writer like the surface of a knee. Carbolized douches were ordered twice daily. The state of inaction of the uterus continued for nine days. Then labor pains set in, but after a few hours complete inertia came on. A few minims of ergot was given with no decided effect. Forceps were then applied, and a healthy child was delivered. There followed no sign whatever of activity. The placentæ were both adherent, and were extracted by the hand in the uterus. The patient suffered a mild type of septicæmia following this labor of nine days, but eventually made a safe recovery.—*Med. Record*, May 18, 1889.

Barbour (A. H. F.) on Saexinger's and Winter's Sections. — Professor Saexinger of Tübingen has published a frozen section of a case that died during the first stage of labor. The points of special interest were the length of the lower uterine segment, the position of the blad-

der, and the reflection of the peritoneum ½ in. above the brim. Dr. Berry Hart's studies on the position of the bladder in labor has shown that during the second stage we have the bladder becoming in part an abdominal organ. The study of Schroeder's section and various others had led the author to believe that this drawing-up of the bladder could not take place till the second stage, for in these sections studied the bladder is just as low down as in pregnancy. But in Saexinger's section the bladder in the first stage was already a partially abdominal organ; and it was not the mere accumulation of urine which raised the fundus, for the utero-vesical peritoneum was above the brim. Associated with this position of the bladder was an unusually long and well-marked lower uterine segment. Other points of interest in this same section were that the placenta, which was divided mesially, occupied rather less than one third of the vertical circumference of the uterus, and averaged ⅛ in. thick. Further, that the posterior vaginal wall was in its upper part remarkably thin—about one half of the thickness of the anterior at corresponding level. Finally, with an external conjugate of about 7½ in. during life, there was a true conjugate of only 3.12 in.

Still more recently than Saexinger's there have been published two other sections by Winter of Berlin. They are both from cases of eclampsia. The interest in these cases centres in the placenta, as the two sections illustrate placenta prævia, and accidental hemorrhage. In the placenta-prævia section the placenta came down to within ⅛ of an inch of the os internum, but was not detached nor was there bleeding from the cervix. The striking feature in the placenta was the way in which it had been flattened by the child's head below the brim and indented by its limbs above it. Winter found by microscopic examination that in the lower part of the placenta the tissue was much condensed, the chorionic villi lay very close and interlocked, so that one could hardly speak of an intervillous space. Between those villi there was nowhere blood, the vessels of this part being completely empty. On their examination Winter bases the statement that the child may interfere with its own circulation to such a degree as materially to affect the aëration of its blood, though scarcely to a fatal extent. It is, however, a remarkable fact that the placenta was so much thinner in its lower third, although the liquor amnii was still in the uterus. Winter's sections showed also that with a further advance in the first stage, there was a still higher position of the utero-vesical peritoneum, with a greater thinning of the wall below it and a more extensive separation of the membranes. These sections, therefore, bear out what the author drew attention to in his own sections of the first stage, that the uterine pains during this stage are expended in thinning the lower segment of the uterus as well as in dilating the cervix. Saexinger's sections show in addition that this elongation of the lower segment may be accompanied with upper displacement of the bladder. Dr. Barbour remarks it as noteworthy that in Winter's sections as in Schroeder's the posterior lip is being taken up more rapidly than the anterior. Schroeder considered this exceptional, while Winter would regard it as a normal occurrence. Further studies from more sections would alone settle this point.—*Edin. Med. Jour.*, June, 1889.

Felkin (R. W.) on Fœtal Malaria, as Illustrated by Two Cases.—In both these cases the mothers were entirely free from the disease. One case was seen in South Africa, the other in Edinburgh.

The first patient complained of a curious sensation in her abdomen. She was over eight months pregnant. On palpitating the abdomen the fœtus was distinctly felt shaking. The patient said that the same thing had occurred on several previous occasions, but never so severely as now, nor had she previously experienced pain. The next night, and again the next, the same thing occurred at the same hour. The patient's husband related that he had suffered severely from intermittent and remittent fever for several years on the west coast of Africa. Just previous to his marriage and for the first month after, he had had several very severe attacks. The wife had never suffered from malaria in any form whatever. On the fourth night the author was again summoned to the patient and again found the child shaking violently. Labor had now begun. After the head had arrived at the perineum, the natural forces failed, and forceps were applied. There was very great difficulty in delivering the body on account of the greatly distended abdomen, caused by an enlarged spleen. After birth the child, within a few

days, had severe attacks of ague. The writer saw one of these attacks, and reports it as very well marked, the cold, hot, and sweating stages being all present.

The second case occurred in Edinburgh. The patient was suffering from pleurisy and bronchitis, and from the effects of a severe beating from her husband. The nurse reported, when the physician first saw the patient, that on the previous evening the patient had complained of pain and "fluttering" in her abdomen. The nurse described it as a "bad quickening," and said it lasted for about an hour. The following evening the same thing occurred. On examination of the patient, the physician was forcibly reminded of the case first described. The next night, a similar paroxysm came on, labor began and soon terminated with the birth of a child of seven and a half months. The infant was very feeble, and presented a slightly enlarged abdomen. The child was kept alive for forty-eight hours, and died in the cold stage of ague, the second attack it had had since birth. In the first attack of ague after birth, the cold stage was very well marked, the child distinctly shivering, and continuing to do so for rather more than half an hour. The hot stage lasted about two hours, and was followed by fairly profuse perspiration, the cotton-wool in which the child was wrapped becoming quite wet. The temperature reached 102.6°. Inquiry into the family history showed that the father had suffered from malarial infection for years, but that the mother had never had ague. In all her last three pregnancies, the mother stated that she had suffered from the curious feelings described.

The author, from these cases, and other considerations, is inclined to the belief that it is just as possible for malaria to be produced in a fœtus in utero, as it is for other diseases, the transmission of which is now undisputed.—*Edin. Med. Jour.*, June, 1889. E. S. B.

MISCELLANY.

Mills (W.) on Scrofula and Tuberculosis in Birds.—According to this author, tuberculosis in birds runs a very rapid course. Symptoms of a serious nature may be absent till within a few days of death, and even death may result without pronounced emaciation.

The moult is a most serious drain on the organism of the bird, hence the frequency of the disease during and soon after this event.

In pigeons, probably in hen birds, the generative organs are especially liable to a form of disease which ends in fatty degeneration, and over-breeding is an important predisposing cause of disease, particularly of tuberculosis.—*Jour. Comp. Med. and Surg.*, July, 1889.

Potts (C. S.) on Three Unusual Cases of Pressure Palsy.—I. Palsy from pressure upon the external popliteal nerve.

T. D., æt. 39, single and a laborer by occupation, gave the following history: Four days before coming under observation he had been on a spree, and had slept for some time sitting in a chair; on awakening the right leg felt numb, and he thought that "his foot was asleep." On attempting to walk he discovered that he could only do so by dragging the toes on the ground, and that the ankle had a tendency to turn in. He had regained some power in the leg, four days after, when the following conditions were found:

Very little, if any, wasting could be made out, sensation was impaired in the toes, dorsum of the foot, and slightly over the tibialis anticus. Flexion and abduction of the foot were performed very imperfectly. There was a slight decrease in the response of the muscles to the faradic current, but there were no reactions of degeneration. The patient recovered rapidly under the use of small doses of iodide of potash and galvanism.

II. Palsy from pressure on the anterior tibial nerve.

J. T., æt. 21, single and a dental student in the university, had, while operating a week previous, stood with the left leg pressed firmly against the dental chair for about an hour. The point on which the pressure was exerted was about two inches below the outer tuberosity of the tibia. When he stopped work he found that his leg was almost powerless, tingling sensations were felt in it, and he was unable, except with great effort, to clear the ground with his toes. The leg gained somewhat in strength during the week.

At this time the muscles of the anterior tibia-fibular region were flaccid and slightly wasted, sensation was slightly impaired in this region and the dorsum of the foot, and

the ability to flex the ankle and extend the toes was almost gone. Partial reactions of degeneration were found in the tibialis anticus, extensor longus digitorum, and peroneus tertius muscles. There was no tenderness over the nerve trunk. Patient recovered under the use of strychnia and galvanism.

III. Pressure palsy of the ulnar nerve.

F. C., æt. 29, single, and who followed the business of a hostler. While interested in a game of checkers two weeks previous, had supported his head with his hand, the elbow resting upon the table for the space of about thirty minutes. He denied having been drinking. On changing his position he noticed that "his hand felt weak and as if pins and needles were running into it." The next day he consulted a physician who ordered a blister placed over the internal condyle of the elbow joint; this, he said, caused some improvement in his condition.

When seen by us, no wasting of the muscles could be perceived, sensation was impaired in the little finger and along the ulnar half of the hand on both palmar and dorsal surfaces. The grip on the affected side was much weaker between the thumb and little and ring fingers and the thumb and remaining fingers as contrasted with the other hand. No reactions of degeneration were made out. Recovered under treatment by strychnia and galvanism.—*University Med. Mag.*, July, 1889.

Taylor (H.) on Labor Completed at Full Term without Rupture of the Hymen.—The woman had been in labor for a considerable time, and the midwife told me that there was something which prevented the head of the infant from passing out of the vagina. I examined her carefully, and found a large semilunar-shaped, tough membrane, stretching quite across the lower two-thirds of the vaginal outlet, against which the head was being very strongly pushed by strong uterine action. With some considerable difficulty I was enabled to slip the membrane clear of the child's head, and the labor was then soon completed. The case seems to me of great interest in a medico-legal point of view, as showing that it is quite possible for a child to be born without a rupture of the hymen taking place, and that therefore non-rupture of this membrane is not a trustworthy sign of penetration having taken place in cases of rape, etc.—*Br. Med. Jour.*, Nov. 3, 1889.

O'Donovan (C.) a Plea for the Use of the Manganese Compounds in Certain Forms of Dysmenorrhœa.—I order the black oxide of manganese by itself, to be put up in capsules, one grain in each capsule, and have yet to hear the first complaint from it. The dose that is usually employed is one grain three times each day, to be taken three hours after each meal, and followed immediately by at least half a glassful of water or milk. I have given doses of two, in a very few instances of three, grains, but I prefer to use the dose of one grain and continue the drug for a longer time, as the system seems to adapt itself to the remedy better, and there need be no fear of disordering the stomach.

The following conclusions may properly be drawn:

1. The manganese compounds are valuable additions to the therapeutics of dysmenorrhœa, from which, in a certain number of properly selected cases, great benefit may be expected.

2. Their use does not interfere in any manner whatever with the administration of iron or the vegetable tonics, but rather aids and is aided by them.

3. The best result from the use of these remedies may not be obtained at once, and failure should not be confessed until after a continuous trial lasting for three months.

4. So far as we know at present, the black oxide of manganese is the most convenient form of administering these drugs.—*Med. News*, April 6, 1889.

Scott (C. E.) on the Black Oxide of Manganese in Dysmenorrhœa.—According to the author the binoxide of manganese is useful in those cases of dysmenorrhœa characterized by a more or less scanty menstruation, associated with pain, and which are *not* complicated with any well-definable local, inflammatory, or organic lesion to which can be traced the cause of the abnormal menstruation.

He prescribes from 2 to 4 grains of the drug in pill form twice a day, half an hour after meals. He sometimes gives at the same time other tonics, as quinine, iron, and strychnia. From its use in forty cases he has never seen any unpleasant effects, which is more than he can say of the permanganate of potash, which, because of its disagreeable effects, he has ceased to use.—*Med. News*, May 11, 1889.

Jaggard (W. W.) on the Dose of Iron.—The author claims that iron is

generally given too freely. To substantiate his claim he quotes from McKendrick the fact that the blood of the body normally contains about 39 grains of iron. As Blaud's pills are often given in increasing amounts as much as 7½ grains of iron are frequently ingested each day. In 25 minims of the tincture of ferric chloride there is 1 grain of metallic iron. That these large doses of iron do harm the author does not claim, but only that they are wasteful and needless.—*Therapeutic Gaz.*, June 15, 1889.

Osler (W.) on Puerperal Anæmia, and Its Treatment with Arsenic.—The author says: "I know of nothing more remarkable in practical therapeutics, nothing so resembling specific action (unless we except iron in chlorosis and quinine in ague) than the rapid recovery of profound anæmia under this drug (arsenic). As a rule it is well borne, and should be given, as Bramwell advises, in increasing doses, beginning with five minims, and rising gradually to twenty or thirty, three times a day. . . . In the case reported vomiting and diarrhœa seemed to improve, for a time at least, when the arsenic was first given. . . . In post-partum cases recovery is always slow. It may be many months before perfect health is restored. It is well to intermit arsenic for a few weeks, but the drug should be given at intervals for many months."—*Boston Med. and Surg. Jour.*, Nov. 8, 1888.

Senator on Laminaria in Stricture of the Œsophagus.—A piece of laminaria is attached to the end of an ordinary œsophageal bougie, and for greater safety this is further connected with a string running through the whole length of the bougie. Different sizes are used according to circumstances. The instrument is passed into the stricture and left in position from half an hour to an hour, during which time the laminaria swells to a considerable extent. In one case it expanded from one to one and a half millimetre in the course of half an hour. The surface of the laminaria remains smooth, and does not injure the mucous membrane. In most of the cases in which Dr. Senator has tried this plan the stricture has been cancerous, and, as he says, although "by gradual and frequently repeated pressure a carcinoma may cicatrize and become atrophied, this very seldom happens." In a large proportion of his cases, however, the treatment produced very marked dilatation of the stricture, so that the patients after a certain time could swallow much better than before. In some instances there was no improvement, and Professor Senator confesses that at first his anxiety to dilate the stricture as quickly as possible made him apply the treatment without sufficient regard for the tolerance of the diseased parts. If due care is not exercised, the laminaria may swell so much as to cause great pain, and even difficulty in removal. The most favorable cases for the treatment are of course those of cicatricial stricture. Dr. Senator points out that laminaria may also be used with good effect in narrowing of other canals, and he relates one case of stricture of the rectum in which he tried it, but apparently with indifferent success.—*Br. Med. Jour.*, June 22, 1889.

Richards (J. T.) on the Combination of Bromide of Potassium with Belladonna for Enuresis.—Two cases of nocturnal incontinence of urine of long duration in boys of twelve years of age, coming under treatment at the same time, have yielded in a striking manner to a combination of bromide of potassium with belladonna, after belladonna alone and other drugs had failed to produce effect. In the first case, the boy had been discharged, on account of the incontinence, from an orphan institution, where he had been admitted with a view to emigration. He had been an in-patient at this hospital four years previously for three months, according to the record of patients, with "scrofulous cystitis, cured by accidentally induced acute cystitis from injections." At this time he was circumcised. The enuresis had lasted from infancy. When readmitted last February, the usual precautions were taken to ensure regular emptying of the bladder at night. An enema was given before sleep, and was successful on the first night or two that it was tried, but not afterwards. Belladonna, iron, saccharin, nux vomica (up to ♏x of the tincture thrice daily), and codeine were given successively, without even temporary effect. On April 15th he was ordered pot. brom. gr. x, tincture of belladonna ♏x, every night, and this was at once effectual. From the time that he took the first dose until May 11th, when he went home, and for a fortnight afterwards, when he was last heard of, no wetting of the bed occurred, excepting once, on the 20th of April, when

he had not been attended to as usual. At this time the dose of tinct. belladon. was increased to ℥xv. The other case was that of an out-patient, where the habit was of equally long standing, and belladonna and nux vomica had been given without benefit for several months. On April 24th this patient was ordered pot. brom. gr. x, tinct. belladon. ℥xx, every night before going to bed, with the same immediate effect as in the former case, which has continued without interruption to June 3d.—*Br. Med. Jour.*, June 22, 1889.

Northridge (W. A.) on the Prevention of Summer Diarrhœa.—For children who cannot be taken to the seaside or the hills, and who are not breast-fed, the author offers the following advice, in addition, of course, to furnishing the best available air and plenty of water:

The mother is directed to obtain two small soda-water bottles. They are strong and can be tightly corked. The rest of the apparatus will be found in every household. A saucepan is to be filled with water, sufficient to reach to the neck of the bottle. The bottles are to be thoroughly washed, filled with milk, and placed in the saucepan, which is laid on the range. A cover excludes the air. In about twenty minutes, or as soon as the milk froths up, the bottles are to be tightly corked and laid in a cool place. Mothers readily understand this procedure, and carry it out successfully. A few cents paid for bottles covers the cost of the apparatus. When the child is to be fed, one of the bottles is opened, and the amount required poured out. The bottle is to be corked, and returned to a cool place. The second bottle is not to be opened until the contents of the first are exhausted. The infant's sanitary surroundings should be carefully inquired into. Mothers should be instructed to keep the child perfectly clean. Soiled linen should be immediately removed. The child should be frequently bathed, and an abundance of fresh air and light afforded.—*N. Y. Med. Jour.*, July 6, 1889.

Raynaud's Disease.—During the past year cases of this disease have been from time to time reported, but none that have come to the notice of the writer has added any thing to our knowledge of the affection.

Dr. J. E. Morgan, in the *Lancet* of July 6, 1889, reports a case of symmetrical gangrene of the finger tips and portions of the ears which was preceded and followed by active and unquestionable syphilitic manifestations, and which healed under specific treatment. The hands were cold and anæsthetic for six weeks before they became painful, blue, and finally showed gangrenous spots on the finger tips. There were no appreciable changes in the arteries of the arms. Dr. Morgan reviews the literature of the subject quite extensively, and leans toward the probable neurotic origin of the disease.

It must be confessed that in this case the paroxysmal character of the typical Raynaud's disease was almost entirely wanting. The prolonged period of numbness before asphyxia and gangrene appeared, with disabling pains in all limbs, might seem to point to a preceding neuritis. The reporter thinks himself justified in excluding arterial disease on account of the apparently normal condition of the palpable arteries of the affected extremities.

In syphilis gangrene of small portions of the skin has been traced to endarteritis of the *terminal* arteries. To the writer the apparently normal condition of the radial does not seem necessarily to exclude the possibility of changes in the terminal arteries in the finger tips any more than does a normal condition of the vessels at the base of the brain exclude miliary aneurisms in the smaller arteries of that organ. A similar criticism applies to a much more typical case reported by Dr. Samuel West (*Lancet*, Feb. 16, '89), which proved fatal from pneumonia. Examination of the radial artery, median nerve, and medulla was negative. Dr. Morgan objects further, with much plausibility, against the supposition of arteritis in his case, that he knows of no instance "in which the symptoms occasioned by that disease were so symmetrically distributed over the terminal arterioles of the fingers, ears, and nose, as in the case I have here detailed." This is, however, begging the question. The same objection might *a priori* have been made against the existence of multiple neuritis.

Several cases have been put on record in which symmetrical gangrene has been found associated with various diseases of undoubted nervous origin. In the *Bristol Medical and Surgical Journal* for April, 1889, is reported one associated with megrim. Dr. Porter (*Lancet*, April 27, '89) reports a case in which local syncope and asphyxia of the fingers alternated with

epigastric pain and vomiting. Dr. W. C. Bland (*Lancet*, April 27, '89) gives the history of an epileptic who suffered from an attack of acute mania, complicated later by hæmaturia, pale retinæ, and obscure vision, and gangrene of several toes; from all of which, except the epilepsy, he recovered. These cases certainly are entitled to some weight as evidence of the origin of the disease in the nervous system. The diversity in the associated nervous symptoms and the doubt which in the case reported by Dr. Porter seems to be legitimate, as to the possibility of vascular disease (*i.e.* arteritis) in that case, leads again to the conclusion which the writer has previously expressed in this journal, that in the present state of our knowledge, symmetrical gangrene and the less severe manifestations of "Raynaud's disease" are to be regarded as symptoms which may possibly result from a variety of morbid conditions, rather than as a distinct morbid entity. R. VAN SANTVOORD, M.D.

Brown (C. W. H.) on Two Cases of Diphtheria Involving a Wound.—CASE 1.—C. C., aged twelve, was seen on February 13th with a sloughing wound the size of a crown-piece over the internal condyle of the right humerus, produced by her mother applying crude carbolic acid to a small spot in that position, which she supposed was a "ringworm." By February 17th the slough had separated, leaving a healthy granulating surface. On February 21st there was an access of *malaise*, with slight fever; the wound, now about as large as a half-crown, having a thin grayish covering at its edges, and the axillary glands being enlarged and tender. On February 22d there were aggravation of fever (101° F.), marked adynamia, and albuminuria; while the wound was covered with a thick ashy-gray pellicle. By February 28th all fever had subsided, and the membrane had separated from the wound, which had regained its previously healthy appearance, the axillary glands still remaining rather large and tender. By March 6th the wound had healed; there was much debility, with anæmia, and still albumen in the urine, but only a trace. On March 10th there was no albuminuria, but general convalescence was protracted. In the course of a few weeks the child experienced difficulty in accommodating for near objects, which was said by an ophthalmic surgeon, who kindly saw her for me, to be due to "probably post-diphtheritic weakness of ciliary muscles." No further paralytic phenomena were developed, and the eyes recovered their normal condition after a little time.

CASE 2.—W. C., aged forty-two, father of the above, contused his right shin on March 7th. The nutrition of the skin of that leg was impaired from varicosity of both saphenous veins; consequently a superficial slough, about 3 by 2 inches, formed at the seat of injury, and was thrown off by March 13th. On March 14th there were *malaise*, rise of temperature to 102°, and a trace of albumen in the urine, with redness round the margin of the wound and tenderness of the femoral glands. By March 15th the patient was prostrate, very anæmic. The urine contained a great deal of albumen, and the wound was covered with a gray membrane. On March 20th a small patch of membrane was seen on each tonsil, and the corresponding cervical glands were much swollen and painful. By March 24th the membrane had separated from the leg, the condition of the throat was much the same, and there was less albumen in the urine. On March 25th the patient was seized suddenly with syncope, and died in ten minutes.

The drugs employed in treatment were: In Case 1, citrate of iron and quinine, with iodoform locally; in Case 2, at first, tr. ferri perchlor. (♏ 15 6ths), and, later, bichloride of mercury (gr. $\frac{1}{16}$), with ferri ammon. cit. (gr. 7), papain and iodoform being used to the wound, and papain and glycerine of boracic acid to the throat.

There was no evidence of direct infection from another case of diphtheria in either patient. In Case 2, obviously the throat may have been infected directly from the leg. A careful perusal of the dates shows that the father was not infected by the daughter directly, though he may have been so indirectly. The sanitary condition of the house where the patients lived was very bad; the drinking-water and milk were good.—*Br. Med. Jour.*, June 8, 1889.

Comingor (J. A.) on the Treatment of Gall-Stone Successful by Massage or "Pumping the Liver."—The patient, a doctor, 50 years of age, from exposure in November, 1885, was suddenly stricken down with the usual symptoms of obstruction of the gall-duct. Of course, jaundice followed. He was treated eleven weeks before I saw him.

From his attendants I received the history of his case and their treatment. The treatment was so full and complete, that there was nothing I could think of to suggest, in the therapeutic line, that they had not used. I therefore suggested that we apply the principles of massage to the case. This we did, and after we were through with the movements, it reminded me so strikingly of pumping, that I called it "pumping the liver." I proceeded by placing my hands on the ribs over the liver, making firm and quick pressure downwards letting up and repeating, say for five minutes, and then requested that it be repeated two or three times during the night. Up to that time no trace of bile had been discovered in the dejections. The following day a large quantity of dark bilious matter passed from the bowels, soon followed by scores of gall-stones. Improvement set in from that day and continued for at least a fortnight, when from some unknown cause another blockade was on hand. The pumping process was resorted to again with the same desirable result as on the former occasion. After this the patient experienced no further trouble and made a complete recovery.—*Va. Med. Mo.*, June, 1889.

Wilson (C.) on Diurnal and Nocturnal Excretion of Urine.—Roberts has shown that in health the excretion of urine, the solid as well as the liquid constituents, takes place at a slower rate during the night than during the day. From his figures we find—the day and night being divided—that while the solid diurnal excretion is, per hour, twice as great as the nocturnal, the liquid is four and a half times as great. The solid constituents are of course more important and more constant than the liquid, which naturally varies with the amount of fluid imbibed, and with temperature, etc. Gley and Richet last year confirmed these observations, concluding that "the excretion of water and nitrogen is much less during the night than during the day." The observations just quoted all refer to the excretion in health. Dr. James argues something like this: Excretion is more active during the day than during the night, probably because the vitality and general vigor of the system is greater in the daytime. If, however, the kidneys are diseased, they will not be able to take advantage of this increase of vigor; in other words, if an organ is sufficiently diseased, it will not be able to do more work at high than it can at low pressure.

The author has studied the bearing of renal disease upon this subject, and has invariably found that, when the kidneys are diseased, nearly as much and sometimes more urine is excreted at night than in the daytime. His cases experimented on included subacute and chronic Bright's disease, Bright's disease with Hodgkins' disease, waxy disease with phthisis, two cases of cardiac disease, and one case of diabetes mellitus. The amount of contained solids and albumen, when present, was also large.—*Lancet*, June 29, 1889.

McNaughton (G.) on a Case of Primary Cancer of the Pancreas.—A woman of thirty-five had enjoyed pretty good health up to October, 1888. She died February 10, 1889. The prominent symptom during her sickness was pain, paroxysmal and neuralgic in character, not fixed, first in region of the stomach, then about the heart, and extending down the left arm to the little and second fingers, then near the umbilicus, and finally, the most excruciating, in the back. She also said that when turning over in her bed she could feel something drag from the back. The occasional symptoms were nausea, vomiting and profuse sweats, tongue red and dry, and fatty stools. The condition of the pulse was usually small and feeble; respiration normal, except toward the end, when it became very slow. This was no doubt due to the morphine and the jaundice. Temperature never high, usually 99° to 99½° F.

Physical Signs.—Resonance tympanitic over whole of the abdomen; easily perceptible pulsation over the region above and to the right of the umbilicus.

Auscultation disclosed a murmur (probably obstructive) which continued to be present from the time it was discovered.

At the autopsy the body was found to be much emaciated and jaundiced. Abdomen slightly distended, some fluid in peritoneal cavity. Descending colon displaced to the right; transverse colon attached to tissues beneath, muscular tissue of transverse and descending colon atrophied; the wall of that portion of the large intestine very thin; mesentery of small intestine filled with hard nodules.

The tumor, which had been examined and pronounced malignant and impossible to remove at an exploratory abdominal

section January 13, 1889, was found beneath the stomach and attached to it. The whole of the pancreas was found enveloped in cancerous tissue.—*Brooklyn Med. Jour.*, July, 1889.

Pietrizkowski on Pneumonias Consecutive to Strangulated Hernia.—Comparatively often do we observe pneumonia as a result of inflammation of the peritoneum, and in particular after kelotomy for strangulated hernia. In old people one might think of hypostatic pneumonia, or of a pneumonia due to the penetration of vomited matter into the air-passages; but in another series of facts these two suppositions are not admissible, especially when we have to deal with strong and powerful young men. Gussenbauer thought that these pneumonias were due to partial emboli which started from thrombosed intestinal blood-vessels. If those emboli contain no micro-organisms, a simple inflammation is produced which is rapidly cured; but if they are derived from a strangulated loop, they determine deep lesions which end in lobar or lobular pneumonia. If we look over the hospital records we find that this pneumonia is produced in 8 per cent. of the cases of operation. But if patients are carefully examined we find light pulmonary manifestations in 30 and even in 50 per cent. of such patients. In the majority of cases the affection is only a simple infarct, and the pulmonary signs disappear in from eight to ten days; in other cases, however, the disease takes the form of pneumonia or pleurisy. Gussenbauer's theory is sustained by this observation, that the pulmonary phenomena come on especially when a strangulation has lasted a very short time. In such cases the clots have not had time to adhere to the parietes. On the contrary, pneumonias are very rare when the strangulated loop has become gangrenous and the circulation has been interfered with. In such cases we must make an abdominal fistula, and in such cases the pneumonia is much more rare than after simple kelotomy. Jaundice is quite a frequent symptom as a result of the reduction of a strangulated hernia; it can also be explained by emboli which have been arrested in the liver; this fact is often confirmed by the post-mortem.

As a result of his experiments on dogs, in which he made artificial strangulated hernias, he found in ten animals on which the operation succeeded, parenchymatous alterations of the lungs and sometimes of the liver, due to emboli enfarcts. In a few cases he was able to demonstrate the formation of a thrombus in the intestinal vessels. The thrombus reaches the lung by the portal venous system and by the inferior vena cava.—*Med. News*, July 6, 1889.

Berthold on Transplantation in Cases of Perforation of the Tympanum.—A part of the human cutis appears to be the best fitted for large perforations of the tympanum. Before applying the transplanted tissue to the mucous surface of the internal ear, all the matter should be carefully cleared out, and any adhesions separated, so that the margin of the mucous membrane around the edge of the wound is brought into a healthy granulating surface. This being done, the small piece of skin is inserted, which should be skilfully cut to fit the mucous surface as a watch-glass into its facet. The hearing is in no way impaired by this operation, but is rather improved thereby, while the healing granulation process is greatly hastened. Berthold has experimented with other tissues, as the cornea of rabbits and skin of frogs, but these do not give satisfactory results, more particularly the latter, which he considers unsuitable. In small holes of the tympanum, however, he thinks the best results can be got from the thin pellicle that covers the egg which lies under the shell. He stretches a small piece of this tissue over the hole, and daily brushes the hole with turpentine. The turpentine irritates the tympanic membrane, produces great redness, the edges of the hole thicken, and the perforation gets rapidly less. The translucent condition of the tissue admits of careful observation, and he finds that seven days after the commencement of application the hole will have quite healed up, and the pellicle have fallen of.—*Med. Press*, June 12, 1889.

Roosevelt (J. W.) on the Movements of the Thorax Considered in their Relation to Certain Pulmonary Diseases.—The author concludes:

1. That it cannot be shown that any part of the lung moves, in proportion to its bulk, in respiration, less than any other.

2. That the part of the lung which actually (not necessarily) must move least is that lying near the inner surface.

3. That it is impossible for the upper lobes to be expanded, in any act of forced

expiration, by air driven into them from the lower.

4. No explanation exists of the frequent selection of any lobe by any inhaled bacterium.—*Med. Record*, May 25, 1889.

Ross (J.) on the Premonitory Symptoms of Alcoholic Paralysis.—The early symptoms of this disease, which the author thinks are often overlooked, are: (1) Disorders of the tactile sensibility of the extremities, which patients usually describe as numbness of the fingers and toes; (2) vaso-motor spasm of the extremities, named by Raynaud "local asphyxia," and which the patients refer to as "deadness" and "coldness" of the fingers and toes; (3) severe cramps, which are most frequent and severe in the muscles of the calf, although these muscles are by no means the exclusive seat of them.—*Lancet*, June 8, 1889.

Laine (D. F.) on a Case of Abscess of the Gall-Bladder.—A woman of seventy-six had suffered from repeated chills for two weeks; was first seen June 16, 1889. Mother and two sisters had died of cancer. Patient herself was the mother of several healthy children. With the exception of rheumatic pains, confined to the left hip-joint and leg, from which she had been a constant sufferer for the past twenty years, she had always enjoyed good health. During the summer of 1888 she had an attack of jaundice which lasted two or three days, but which was not accompanied by any hepatic colic nor the passage of gall-stones. For the past two weeks she had complained at various times of severe, sharp, shooting pains, which extended from epigastric across hypochondriac regions to right shoulder blade; these were frequently followed by a chill, with fever and sweats. I found the patient on my arrival suffering from a marked rigor, with pale face, blue lips, and cold extremities, a rapid, weak pulse, hurried breathing, and skin covered with clammy perspiration. The tongue was furred, and a few minutes previously she had vomited about two ounces of a clear, yellowish liquid. The thermometer in the axilla indicated a temperature of 102½.° On the following day a careful physical examination revealed the following conditions:

Conjunctiva very pale and anæmic, but no jaundice. The skin had a waxy appearance, but the body was well nourished. Lungs normal. Heart sounds clear, with marked systolic murmur at the base. Area of splenic dulness normal. Slight tenderness over the region of gall-bladder, only produced on deep pressure. The edge of the liver could not be felt on account of the thickness of abdominal walls. Liver dulness normal. No tumor or resisting body could be felt during the examinations or at any time subsequently. Specimens of the urine and blood were repeatedly examined, but with negative results.

At the end of a few days I came to the conclusion that we were dealing with a case of Charcot's hepatic intermittent fever. Quinine, opium, and whiskey were freely used, but she continued in the same condition for several weeks. The chills, fever, and sweats returned every third, fourth or seventh day, and the pain in her side remained more or less constantly.

Her tongue continued coated, appetite poor, and bowels slightly loose. The stools were carefully examined for any evidence of gall-stones. Once or twice very hard, yellowish bodies were found, which on more careful examination proved to be undissolved capsules of quinine. On August the 14th she developed an inflammation of right parotid gland, which in two or three days subsided. On August the 25th there was marked dulness over a circumscribed area of left lower lobe, with bronchial breathing and large mucous râles. The expectoration soon became purulent, mixed with blood, and very abundant. Death took place on the 6th of September. At no time during her illness was there jaundice, nor could a tumor be felt under the right costal margin.

An autopsy, eight hours after death, revealed the following conditions: On opening the abdominal cavity a small abscess was found occupying the region of the gall-bladder. The walls of the latter were entirely destroyed, and the pus had burrowed in different directions, one of the sinuses extending across the median line through the substance of the great omentum. A small calculus was found in the cystic duct, occupying its entire lumen, and another about the size of a hickory-nut in the dactus communis cholidochus. The passage of bile was not interfered with. The substance of the liver was healthy. Two septic abscesses were found in the lower lobes of the left lung. There were small vegetations on the aortic valves.—*Univ. Med. Mag.*, July, 1889.

Remington (F.) on a Case of Strangulated Hernia Mistaken for one of Uræmia in a Patient Known to be Suffering from Chronic Interstitial Nephritis; Autopsy.—N. F—, the patient, was a housekeeper, sixty years of age, suffering from chronic mania. The family and personal histories were negative, the habits unknown, and the previous health good. She was well developed and nourished. Heart enlarged to left. Accentuation of second aortic sounds. Some œdema of hands and feet, and some puffiness of eyelids. Examination otherwise negative.

Urine — Amount varied from 70–90 ounces in twenty-four hours. Specific gravity, 1.010–1.008. Albumin $\frac{1}{8}$–$\frac{1}{16}$ of one per cent., and the sediment contained a relatively large number of small hyaline and fine granular casts. During the patient's stay in the asylum she frequently suffered from slight uræmic attacks, as was evinced by some œdema of feet and eyelids, vomiting, and vertigo. From these attacks she usually recovered after a rest of a day or two in bed.

The patient's appetite had been poor for several days, and she had been losing weight rapidly. One day she had some swelling of feet and vomiting; there was also diarrhœa. Morphine, gr. $\frac{1}{4}$ by stomach, was given to relieve the vomiting. The urine was passed involuntarily, and its amount cannot be estimated. During the next two days the patient's symptoms grew rapidly worse, and she died three days later at noon, no new symptoms having developed.

Autopsy.—The heart walls were greatly thickened, and showed evidence of granular degeneration. There was calcification of the aortic flaps. The mitral orifice admitted five, and the tricuspid seven, fingertips. The weight of the heart was twenty-two ounces.

The kidneys were decreased in size, their surface was uneven and capsule adherent; surface granular; cortex was very thin and dense on section; pyramids injected; weight of both kidneys five ounces.

Projecting through the internal inguinal ring on the right side, into the inguinal canal, there was a hernia of the middle portion of the small intestine. The intestines were agglutinated to the hernial sac. The included knuckle of gut was gangrenous and leathery, and easily broken through. The hernial sac contained about two ounces of a yellowish stercoraceous material. It was impossible to reduce the hernia. Below the constriction, the intestines were empty, while above they were filled with gas and semi-fluid, yellowish, not especially feculent, fæces. There was absolutely no tumor produced by the hernia, and there was no symptom which was not in keeping with a uræmic attack. Of course, the patient was unable to give satisfactory subjective symptoms, and under the circumstances a more rational conclusion could not have been arrived at than the opinion formed by every one who saw her, that she was suffering from uræmia.—*Med. Record*, July 6, 1889.

Minich (A. K.) on the Window in Typhoid Fever.—In about two years' practice the writer has lost six convalescent typhoid patients from a pneumonia developing in the side of the chest nearest the window, and thinking the exposure caused it, he took the temperature in his own room, warmed by a heater in the cellar, with the following results. It was January 29, 1889. On the inside window-sill it was 61½°, three feet from the window-sill it was 64¼°, and eight feet from the same place it was 68½°. For a considerable time now he has not permitted a typhoid's bed to be parallel with the wall containing the window or windows, and he has had no pneumonia since.—*Med. Register*, February 16, 1889.

BOOK NOTICE.

American Resorts, with Notes upon Their Climate. — By BUSHROD W. JAMES, A.M., M.D., etc. Intended for invalids and those who desire to preserve good health in a suitable climate. F. A. Davis: Philadelphia and London, 1889. Octavo, 300 pages, cloth, price $2.00.

This volume appears to be essentially a complete list of American resorts. Most of the places mentioned might be suitably called "last resorts," yet probably many of those who consult these pages will be surprised to find that our country is so rich in sanitary and pleasure-giving resources. The necessity of foreign travel disappears in view of the immense number and variety of attractions at home. But the throng of those in search of health and diversion will no doubt still continue to obey the dictates of fashion, and the European spas and health resorts are likely to suffer no decrease of popularity. From a scientific standpoint, by far the most valuable part of the book is contained in the ninety-six pages devoted to the translation from the German. However, it contains many details of information not elsewhere collected.—C. H. K.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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MEDICINE.

Zenner on Silver-Gilders' Cramp.—The patient presents a professional neurosis which has not hitherto been observed, so far as the writer knows. His occupation requires the application of silver leaves upon the moulding of frames. In the performance of this act the arm is held out freely, without support, the elbow on a line with the chest and at quite a distance from it, while there is a constant flexion and extension of the elbow so as to bring the hand first to the silver leaf and then to the moulding where the leaf is to be deposited, and at the same time a flexion and extension of the wrist in picking up and laying down the leaf. The man has been doing this kind of work for seventeen years. The greater part of the day is devoted to the kind of movements just described. A smaller part of the day he burnishes the gilding. His trouble began about six months ago. He first observed that his arm was drawn to the body, the elbow held firmly against the latter, so that the arm was no longer held out freely while the movements of flexion and extension of elbow and wrist were made. Shortly thereafter he began to suffer with pain, chiefly in the anterior part of the wrist, the inner side of the arm, and at a part near the shoulder; also, he had occasional cramps in the arm, and the arm was more or less tremulous. He has continued at his work, but is unable to do as much as before, and does not do that as well as formerly. But while he has this difficulty in performing these accustomed acts, the arm appears to retain its full power, and other acts, for instance burnishing, are performed as well as before.

An analysis of the case shows its essential features to be like those of other professional neuroses. The most specialized muscular actions are the earliest impaired. In this instance it is the act of holding the elbow freely away from the body, while the mere flexing and extending of wrist and elbow are less specialized and less affected. At the same time, in the first movement just referred to there is persistent muscular contraction, while in the acts of flexion and extension there is continuous contraction and relaxation of muscles.

The pathology of the disease is obscure. It is a question whether the trouble is peripheral or central. The writer gives reasons for believing that both central and peripheral parts of the nervous system are at fault.

In the patient described there were no other symptoms of nervous disease. The optic discs, pupils, and tendon reflexes were normal, and no impairment of motion or sensation was anywhere manifest.

The only radical cure for the patient is changing his occupation. Various internal and external remedies have been used, with some relief of his symptoms.—*Cincinnati Lancet-Clinic*, July 13, 1889.

Munro (J. C.). Report of Twenty-four Cases of Acute Miliary Tuberculosis.—The author concludes that the cases studied by him would seem to indi-

cate that an acute pulmonary tuberculosis should be suspected when the following indices are present (the existence of other pathological conditions in the lungs giving rise to characteristic signs and symptoms that ought not entirely mask those under consideration): Sudden severe illness, ushered in with a chill, in a person previously healthy or with a history of chronic phthisis; slight cough and expectoration, no hæmoptysis, marked loss of flesh and strength; loss of elasticity, or a slight dulness over part or the whole of a lung or surrounding a limited area of marked dulness; indistinct, harsh respiration, with high-pitched inspiration and prolonged low-pitched expiration; a few scattered fine dry or fine moist râles, generally high-pitched; a rapid, weak pulse, with quickened, shallow respiration, and cyanosis out of proportion to the physical signs; a temperature steadily feverish, but without marked variations; local evidences of miliary infiltration in other organs.—*Med. News*, July 20, 1889.

Greene (J. L.) on Pneumonia Treated with Peroxide of Hydrogen.—The author's cases were mostly those of the congestive form of pneumonia common in the high altitudes of the Rocky Mountains. Of 23 cases he has lost but one, that being a puny infant of 11 weeks.

In the congestive stage the author gives ½ to ¼ a teaspoonful of the peroxide of hydrogen, well diluted in water, once in five or ten minutes for an hour or more, with good results. In acute lobar pneumonia he usually gives half a teaspoonful, diluted, every hour until after the crisis occurs.—*Med. Record*, July 20, 1889.

Bowditch (V. Y.) on Comparative Results in Ninety Cases of Pleurisy, with Special Reference to the Development of Phthisis Pulmonalis.—The results of the author's investigations show at least:

First. That whether we can prove absolutely that all pleurisies are tubercular or not, yet a large percentage of these patients who were afflicted with pleurisy, often in apparently chronic forms, recover their health and have never had any recurrence of the original trouble nor development of subsequent pulmonary or otherwise tubercular trouble.

Second. That while undoubtedly there are many cases in which an attack of pleurisy is followed within a comparatively short space of time by pulmonary trouble; and, therefore, special care should be taken of the patient during convalescence from the former disease, yet we are not justified in giving such gloomy prognosis as we should be inclined by accepting the extreme views held by Landouzy and his followers.

To give hope and courage to patient and friends should be the first effort of every physician.—*Med. News*, July 20, 1889.

Ring (G. O.) on Cases of Unusual Foreign Bodies in the Nostrils.—In the first case, a rhinolith weighing 55 grains entirely occluded the left nostril. It consisted of nasal salts deposited upon an iron screw about one inch long. In the second case, a still larger iron screw formed the nucleus of a large rhinolith, which reposed in an atrophic depression in the lower anterior portion of the cartilaginous septum.

In other cases there were removed: a shoe-button after a lodgment of 3 years; a rhinolith the size of a cherry, having for a nucleus a small folded piece of paper; a shoe-button inserted 2 years previously; and in another case the same foreign body, which in 3 days had brought on a profuse muco-purulent discharge; a peanut kernel; and lastly a rhinolith as large as a marble, with no nucleus, but a small particle of inspissated mucus.—*University Med. Mag.*, August, 1889.

Movable Heart.—Of five cases of movable heart studied by Professor Rumpf, three were the results of dietetic and medicinal attempts to cure obesity, one occurred after violent nervous excitement, and in one no cause could be assigned. The chief complaint of the patients was great debility and incapacity for work; other symptoms were pains in the chest, uneasiness, anxiety of mind, vertigo, asthma, and accelerated pulse. One symptom especially is always present in these cases: all the signs become less in the patient when lying on his back, and worse when he is on his side, and he feels better when he is standing up, though the pain does not disappear; occasionally, however, there is vertigo and malaise. The examination of the heart in the erect or horizontal position, and with the thorax bent forward, shows nothing whatever abnormal; when, however, the patient lies first on the left and then on the right side the abnormal mobility of the heart becomes very distinct. In one case the apex beat shifted 13 centi-

metres, in another from 4 to 5 centimetres. When the patient lies on his left side the area of the cardiac dulness seems larger, when on his right smaller, while at the same time the position of the aorta and of the pulmonary artery is also changed; in one case they moved 1 centimetre in the direction of the displaced heart. Dr. Rumpf considers the movable heart to be not a mere irregularity, but a pathological symptom, as the average normal movement of the heart is at most 2 centimetres to the left and 1½ centimetres to the right, and as he observed this dislocation in one case of tuberculosis of the lungs and in one case of muscular atrophy.—*Lancet*, July 13, 1889.

Hare (H. A.) on the Treatment of Gastric Digestion.—In cases where there is reason to believe that gastric digestion is imperfect, common salt should be used in increased amount in the food, so that the quantity of hydrochloric acid may be increased. If, however, there is reason to believe that lactic acid is present in too small a quantity to split up this salt, then hydrochloric acid must itself be used, and where it is employed given freely in order not only to act thoroughly itself, but also to perform an equally important function, namely, the conversion of pepsinogen into the active body pepsin. In other words, deficiency of pepsin in the juice is to be corrected not by a prescription containing much pepsin and little acid, but rather the reverse, for the pepsin in the prescription is after all an extraneous product, while the pepsin brought into being by the acid is a normal secretion. Of course the quantity of pepsin must depend on a normal formation of pepsinogen, but it should not be forgotten, on the other hand, that as pepsin acts by catalysis, and is a most powerful ferment, only very small quantities of it are absolutely necessary, while large amounts of hydrochloric acid, comparatively speaking, are essential.

In an article recently published in the *Revue Médicale de la Suisse Romande*, Bourget has enunciated some thoughts which are so completely in accord with the views here expressed as to be worthy of quotation. He believes, as does the writer, that the hydrochloric acid is generally the secretion which is lacking in amount, and recommends its free employment as the most important part of the treatment of gastric indigestion. He does not seem to do this because he believes it to increase the pepsin, but only because he thinks the acid secretion is more apt to be deranged than is that of the ferment. According to my own practical experience and the much more reliable information gained by experimental research, it is to be concluded, therefore, that pepsin is to occupy the least prominent position in a prescription for gastric disturbance, and that the acid is to be freely used. Indeed, I am so surely convinced of the importance of the acid in its double sphere that I fear I am sometimes inclined to give almost no pepsin at all.—*University Med. Mag.*, August, 1889.

Granville (J. M.) on a New Treatment and Possible Cure for Cancer.—In the attempts which have from time to time been made to bring tissues infiltrated with cancer-cells or the seat of malignant disease, in either of its forms, under the influence of the disintegrating power of papain, it seems to have been forgotten that the condition of success is the preliminary or simultaneous reduction of the vitality of the part to be "digested." This condition of lower, or temporarily lowered, vitality exists in the case of those proliferative or exudative growths in which papain has been shown to exert a powerfully destructive influence.

By combining the action of a strong depressant with papain, given internally, and, where possible, at the same time applied externally, the action of the papain seems to acquire a marked degree of potency.

I will not at present say more, but simply ask the profession to make calm and unprejudiced trial of the following formula: ℞ Papain, gr. 3; thallin, gr. 2; glycerini tragacanthæ, q.s. ut fiat pilula. One pill to be taken every third or fourth hour, and, if well tolerated, the dose to be increased to two pills. If there seems to be need of a further increase, it is well to give the pills singly every hour instead of giving more than two at once, as the thallin is not generally well borne in doses exceeding four grains. The papain may be increased somewhat more rapidly than the thallin, but I do not think that it does much good in greater proportion to the thallin than as three to two. For external use the same proportion of the two drugs may be applied, either sprinkled on an open sore or gently inuncted with lanolin as a vehicle.—Anonymous letter to the *Lancet*, June 20, 1889.

Granville (J. M.) on a new Treatment and Possible Cure for Cancer.—The author supplements his brief statement, which appeared in the *Lancet* of June 20th, by two or three remarks which have been suggested in the course of inquiries addressed to him by medical practitioners desirous of making trial of the treatment he has described.

He says: "1. It is obvious that if the solvent or digestive power of the papain is to be brought to bear on the morbid growth it must not be exhausted by being first mixed with food. This is why I recommend *very frequent* administration of the papain and thallin, and their combination in the form of pills. The aim is to get absorption of the drug, not local action in the stomach, except in cases of cancer of that organ, in which variety of the disease I give, besides the pills, papain suspended in water with thallin and an alkali, the mixture being protected from light in a dark bottle, for thallin undoubtedly undergoes change on exposure. With a view to further prevent exhaustion of the papain, I direct that the patient shall be fed as exclusively as possible on a vegetable diet, and that the pills shall be taken before, or in the intervals between, meals rather than close after them.

"2. I have not found the thallin, exhibited as I have described, exert any injuriously-depressing effect on the organism as a whole. The principle is to depress the vitality of the morbid growth, and this *seems* to be accomplished in its saturation with the thallin and papain *locally*, by applying a strong paste of the two drugs in combination, or, when practicable, by their inunction. It has been suggested that the lanolin should be rendered thin enough for use in this way by the addition of glycerine, but the strength of the application must not be too greatly reduced by dilution. The results obtained so far are encouraging, and make it clear that the method will deserve a full and fair trial by the profession."—*Lancet*, July 20, 1889.

De Schweinitz (G. E.) on Headache after Cataract Extraction Cured by Antipyrin.—Occasionally, as the author says, after an extraction, even when no complication exists, the patient will complain of severe headache, brought on perhaps by excitement about the operation, or by the pressure and warmth of the bandage. In such instances he thinks antipyrin theoretically indicated, and has found it practically useful in the single case in which he has tried it. Ten-grain doses sufficed.—*University Med. Mag.*, August 1, 1889.

THERAPEUTICS.

Hare (H. A.) on a Case of Singular Insusceptibility to Drugs.—The patient was an hysterical woman of 30, suffering from headache. Other remedies failing, muriate of pilocarpine was tried. One eighth of a grain was given hypodermatically in the arm, and repeated in twenty minutes, with no effect. Ten minutes later a similar dose was given, with no result. A quarter of a grain of a different preparation was administered, with no result, although the patient was watched for over two hours. Twenty drops of Tr. cannabis ind. every four hours failing to relieve the pain, half-grain pills of the solid extract of cannabis were given every three hours, and later every hour, with no effect;—15 grains in less than forty-eight hours.

Same afternoon rise of temperature being noticed, six powders of calomel, each gr. ½, were given, and then gr. xv. of quinine bisulphate, with no effect on fever or buzzing in the ears. She took 40 to 50 grains of quinine every day for three days, with no signs of cinchonism. Once she was given 60 grains of antipyrine in sixteen hours, without any physiological effects.

The writer considered all the symptoms hysterical.—*University Med. Mag.*, August, 1889.

Whittier (E. N.) on Antipyretics.—The author defines fever as a symptom complex, in which disordered heat occupies the dominant position, and is necessarily the essential feature, and associated therewith so intimately as to be a part of the process, are the derangements in the functions of the circulatory, respiratory, muscular, digestive, glandular, and other structures.

Antipyresis is defined to include all measures taken to reduce temperature and to resist the noxious influence of the various infectious and toxic fever-producing agents. Antipyretics are divided into antifebrile and antithermic remedies.

Antifebriles include the false antipyretics, so-called, which act on the vaso-motor system, and all measures which are conducive

to the abstraction of heat, and at the same time to the impartment of tone to the nervous system or to the energizing nerve centres. Under the head of antithermics are classified the modern synthetical compounds which belong to the aromatics. The most valuable feature of the whole paper is the phenomenal showing by the author of the powerful influence in the control of infectious diseases of the reduction of temperature in the energizing nerve centres through the means of cold baths as antifebrile agents. A careful review of the various papers that had been written on the subject showed that results of treatment by all previous and present methods for the control of infectious disease (chiefly typhoid) and the reduction of the mortality rate are insignificant as compared with the results obtained by cold baths and antifebrile remedies. Statistics were collocated and reduced to tables to likewise show that no other method had ever shown any results approaching this in the reduction of the mortality rate.—*N. Y. Med. Jour.*, July 27, 1889.

Browning (A. G.) on Sulphonal: Its Dosage and Effects.—In the experience of this writer sulphonal has shown itself an unsatisfactory, erratic drug.

Case I.—A plethoric man of forty on the verge of delirium tremens, and sleepless. Forty grains of sulphonal in four hours. No sleep, and worse than before, with giddiness, nausea, and general wretchedness all the following day.

Next evening at eight 40 grains in one dose; at twelve talked wildly, had tremors and needed restraint. Gave 15 grains more; uproar continued till 5 A.M. when he slept. At 3 P.M. patient could be aroused, but was incoherent and quickly relapsed into a stupor with cyanosis and some stertor. Was confused, dizzy, and uncomfortable for two or three days—all the time sleepy and dull.

Case II.—Anæmic male of eighteen. Gave gr. xx. sulphonal and repeated in two hours, with no effects. Next night, gr. xl. In four hours excitement, and at midnight delirium with delusions and tormenting priapism. Lethargy with frontal headache, vertigo, and muscular inco-ordination during night and following day. Not himself for five or six days.

Case III. — Nervous male of forty. Troubled with insomnia and neurasthenia. Steady drinker, poor eater. Sulphonal gr. xxx. first night: no result. Next night gr. xl. and in two hours gr. xv. more: no sleep; next day depressed, confused, staggering, as if drunk; nausea, vertigo, and frontal headache. Two weeks later gr. xv. had pleasant result. On a later trial the original trouble was intensified.

Case IV. — Hysterical colored girl of seventeen with choreic movements and insomnia. The first night gave gr. xx. suphonal; repeated in an hour: no sleep. The next night gave gr. xl., and gr. xv. in two hours. Did not sleep, and choreic movements were intensified into "fits." Patient finally got well under bromides and arsenic. *Med. Record*, July 20, 1889.

Lewis (M. J.) and De Schweinitz (G. E.) on the Use of Eucalyptus in Headache.—Eucalyptus has been used with asserted success in migraine and other forms of neuralgia. In our experience it appears to be of most service in the headaches of congestive type; in one case where indiscretion in diet precipitated an attack the drug did not appear to be of use, although it relieved other seizures. In this and other of our cases the drug acted more beneficially when given at the very onset of the attack than after full development of the paroxysm, and we would suggest its trial as early as possible in the seizure, especially when there is a long prodromal period. The question has arisen, Are the headaches of a malarial origin that are relieved by this drug, or has it some other mode of action? In the first case the evidence of malaria is undoubted; in none of the other cases is it positive, and in some not at all probable. In two instances our results were entirely negative; in both an organic lesion existed, the one in the alimentary canal, the other in the ovaries. We have used the drug in one case of ciliary neuralgia without effect. Five minims of the oil of eucalyptus four or six times a day is the ordinary dosage.—*Med. News*, June 20, 1889.

Randolph (R. L.) on a Clinical Study of Some Antiseptics in the Treatment of Otorrhœa.—With reference to various antiseptics employed about the ear the author says:

"1. Carbolic acid, to get its full antiseptic value, must be employed in a solution too strong to be used in the ear without doing positive harm. 2. Iodoform will not be tolerated by the majority of patients, and did not give me as good results as

boric acid. 3. Inasmuch as the recent experience of aural surgeons has shown that the use of boric acid in the powder form is associated with danger, I comparatively seldom used the agent in this form. In the saturated solution boric acid is a valuable agent. 4. If the ear be thoroughly cleansed with warm water, and the acid sublimate solution be allowed to remain in for ten minutes or more, and the ear then closed with a pledget of cotton which has been moistened with the solution, the clinical observations of the past few months have led me to conclude that this solution has a somewhat larger field of usefulness, and will show a somewhat larger percentage of cures than the other three agents."

The following is the author's formula :

℞	Bichloride of mercury . .	gr. ss.
	Tartaric acid	gr. xx.
	Water, to make	℥ v.

Med. Record, July 27, 1889.

Finacune (M.) on Paraldehyde as a Hypnotic.—The use of the above drug is, I believe, becoming extensively known and its qualities appreciated. I find it a perfectly safe and, if given in large enough doses, a very effective remedy. The usually known dose is practically useless, any thing less than one drachm and a half producing little or no effect. The immediate observed effects are quiet and refreshing sleep, the average being seven to eight hours ; on waking the patients do not feel the effects produced by other drugs, such as hyoscyamine—*e. g.*, headache, drowsiness, and dryness of mouth, etc.; the heart and pulse are increased in frequency and force, aud the general effect is that of a diffusible stimulant. It is of the greatest use in all forms of maniacal excitement, with extreme restlessness, and in cases of restlessness with dementia, whether paralytic or otherwise. The value of the drug is seen in cases such as general paralysis, where hyoscyamine is obviously wrong, and opium and its preparations often contra-indicated by the presence of renal disease.—*Lancet*, July 6, 1889.

Garland (A.) on Antipyrin in Chorea and Tetanus.—A boy of 12 had an attack of acute rheumatism last year, without complications, from which he completely recovered under large doses of salicin. When seized with present illness had been suffering two days ; spasms almost continuous, day and night ; semi-delirious. After twenty-one days' treatment by various methods without avail, chloral and bromide of potassium failing to produce sleep, antipyrin in 10-grain doses every four hours was given in the afternoon. That night he slept well, next day the choreic spasms were less frequent, and in three days he was practically well. I may add that, at a consultation with two other medical men the day before the antipyrin was given, the prognosis was considered by all to be most unfavorable.

Last week I gave antipyrin in tetanus, and although the case terminated fatally the spasms were much relieved by the drug, more so than by the doses of chloral 3 ss. and pot. bromidi gr. xv., every four hours. —*Br. Med. Jour.*, July 6, 1889.

Strophanthus as a Local Anæsthetic.—Many of the drugs which are useful in the treatment of cardiac disease also possess a local anæsthetic action. There is, of course, no connection, as far as can be seen at present, between the two actions. The local anæsthetic action of erythrophleine was investigated last year by many observers ; the conclusions arrived at were that, although it possessed a powerful local anæsthetic action, it causes irritation and dilatation of the vessels of the conjunctiva, and in some cases even severe inflammation. It was thus much inferior to cocaine, whose action is accompanied by a constriction of vessels and consequent pallor of the part. Helleborin, the glucoside from the Christmas rose, is also a local anæsthetic and cardiac tonic ; one fortieth of a grain in solution placed on the conjunctiva of a rabbit causes complete anæsthesia in fifteen minutes, and there is at the same time no inferference with the movements of the pupil and no dilatation of vessels. The action of the glucoside is therefore like that of the alkaloid cocaine ; but it has not yet come into general use. Steinach has lately shown that strophanthus seeds contain a body not identical with strophanthin, which when placed on the conjunctiva produces in twenty-five to thirty minutes complete anæsthesia, lasting from two to twelve hours. There are no great signs of irritation, but if applied to the eye of man it causes a slight feeling of burning, with a passing hyperæmia of the conjunctiva. This condition may pass on to cloudiness of the cornea in animals. The local anæsthetic action of strophanthus is, therefore, chiefly of pharmacological interest, like that of erythrophleine. Co-

caine still holds its own when judiciously employed.—*Br. Med. Jour.*, June 22, 1889.

Macfarlane on Fatal Alcoholic Poisoning in a Child.—A boy, aged five years, was in good health playing on the street, when his mother called him in for dinner. A few minutes elapsed between the time the child was called until the mother was prepared to place him at the table, not over twenty minutes. When she looked around for the child she saw that he appeared to be intoxicated. In the sitting-room there was a bottle containing some six or eight ounces of whiskey, along with some cake—a visitor had come in and been treated by the mother. She found the bottle empty. This occurred between twelve and twenty minutes after twelve. The child was put to bed to sleep the liquor off. After the child had taken the whiskey, it became blanched, and this was followed, in an hour or so, by purging and vomiting. About six o'clock I saw the child. It had a rapidly running pulse and a normal temperature. The pupils of the eyes were dilated, and did not respond to light. There was slight twitching about the face, and an occasional tremor about the hands and fingers. I put my nose to the child's breath and it was identical with that of a man who has been intoxicated with whiskey. I did what I could for the patient under the circumstances. I gave it bromide of potash, and coffee. I saw it again at eleven o'clock, and found it in general convulsions. It died about eleven hours from the time it took the liquor.—*Pittsburg Med. Rev.*, July, 1889.

The Use of Phosphorus in Small Doses in the Treatment of Rickets.—For the past two years Dr. Mandelstamu, of Kazan, in Russia, has been using phosphorus in small doses in the treatment of rickets, and during that time he has administered the drug to 214 patients of different ages suffering from various forms of the disease. Of these patients 120 were cured, 43 showed much improvement, and for the rest the medicine had to be withheld owing to the development of intercurrent disorders. The children were given the phosphorus for several months and even for a year. The dose was one centigramme to 1,000 grammes of cod-liver oil, one dessertspoonful once or twice a day. After two months of this treatment the bones of the skull became more compact, and the fontanelles and sutures less prominent, the nervous crisis and the paroxysms of laryngeal stridor less frequent and pronounced. The patients increased in weight, and the general health manifestly improved. The author did not observe any inconvenience arising from the use of the drug. The phosphorus seems to act beneficially upon the dyspeptic signs which accompany rickets. But he remarks that it is best, in those cases in which catarrh of the stomach and intestines exists with tenesmus, to cure this condition before proceeding to administer the phosphorus. He concludes as follows: Clinical observations perfectly justify the employment of phosphorus in rickets. Phosphorus acts better, more quietly, and more surely than any other drugs. The administration of the drug for a long time in small doses is well borne by children and does not produce any ulterior effects. Phosphorus acts favorably especially in cases of symptoms depending upon the ricketty diathesis. Under the influence of phosphorus, in the great majority of cases the development of the disease is arrested. —*Med. Press*, July 17, 1889.

Disinfection of Hands.—MM. Roux and Reynès have tried the method recommended by Dr. Fürbringer, of Berlin, for disinfecting the subungual portions of the fingers with alcohol at 80° C. After thoroughly washing and brushing their hands with hot soap and water, then with carbolic acid at 10 per 1,000, they scraped the subungual portions with a short, rough, thin wire, previously sterilized. The wire was then placed in gelatine, or in agar-agar. Forty-eight hours afterwards the cultivations became liquefied, owing to the numerous colonies they contained. This experiment was repeated twelve times with similar results. The authors then scraped their nails by a mechanical dry process, and after washing and brushing their hands in hot soap and water they washed and brushed them in alcohol at 80° C. After the alcohol evaporated they again washed and brushed their hands in an antiseptic solution. Out of forty experiments, aseptic results were obtained thirty-three times. Out of eight clinical attempts, these results were obtained four times. The authors conclude that the method is superior to the method ordinarily employed, and may be applied with advantage in abdominal surgery and gynæcology.—*Br. Med. Jour.*, July 6, 1889.

SURGERY.

McNaughton (H.) on Auto-Elimination of an Abdominal Tumor through an Exploratory Incision.—A woman, aged twenty-eight, with a good family history and the mother of two healthy children, made a good recovery from the last accouchement, which occurred on March 19, 1886, and was able to nurse her child.

At that time my attention was called to a tumor which occupied the left and central part of the abdomen. It was of a flattened pyriform shape, about ten inches long and six inches broad, its long axis being at right angles to the spinal column. It occupied the umbilical and left lumbar regions. It was smooth and elastic, and enjoyed a wide range of mobility. Without giving her pain, it could be pressed into the right iliac fossa or upward under the liver; it could be rotated on its axis nearly one hundred degrees, but this movement caused a sharp pain and some sickness. She informs me that she could feel the lump ever since childhood, and that it has been slowly increasing in size; but her general health continued very good, and up to this time there were no symptoms that could be referred to the tumor.

Early in September, 1887, she complained of sharp pain in the abdomen, and had a good deal of sickness and high fever, which disappeared after a few days' rest in bed.

In January, 1888, it was very evident that the tumor was rapidly increasing in size. The abdominal measurement at the umbilicus was thirty-five inches. The dulness now extended to the right as far as the ascending colon. There were œdema and pain in the left leg, and some swelling of the inguinal glands of that side. The abdominal pain had now become severe and persistent. Her evening temperature was 102°, with a slight morning remission. Her appetite failed and she emaciated rapidly. The skin of the whole body assumed a yellow tinge. The tumor could not now be moved about, having become adherent to the abdominal wall. She was forced to keep the dorsal position.

After careful consideration and consultation, it was decided that an exploratory incision should be made with a view to the removal of the tumor if found practicable. On the 22d of March the peritoneal cavity was opened by a median incision about four inches long. When exposed the tumor presented a very bluish appearance, as if gorged with venous blood. It felt spongy to the touch; its whole anterior surface was firmly adherent to the abdominal wall. On breaking down some of these adhesions, on either side of the incision, the hemorrhage was very free. A hypodermic needle was inserted into the tumor in several places, but nothing was withdrawn except dark blood. Having concluded that the safe removal of this vascular mass was impossible, the incision was closed and the ordinary dressings applied. The fever, dyspnœa, and emaciation continued, but the pain was much less severe than before the operation. Primary union occurred in the wound, but on the 20th of April it reopened, giving exit to a free discharge of thin dark-colored pus. The discharge of pus and broken-down fragments, some of them quite large, continued with brief periods of intermission until the 1st of October. It ceased definitely about the middle of October. During this period the area of dulness and the size of the abdomen slowly diminished, and the general condition of the patient gradually improved; the œdema disappeared from the leg and the fever subsided.

January 1, 1889. Her health seems now to be fully established; pulse 82; respiration 16. The renal function is normal and her appetite is good. Her weight is three pounds more than before her illness. The skin has regained a healthy color and the muscles are firm; in fact, the cicatrix is the only trace remaining of the long illness that she had. The abdominal circumference at the umbilicus is now twenty-five inches. Regarding the nature of this tumor two medical men in good standing, who saw the patient several years before her late illness, told her she had a movable spleen. In support of this view I may refer to the situation of the tumor, its form, its appearance, and its feeling to the touch when exposed. Besides, though the patient has been repeatedly examined since her recovery, no splenic dulness can be made out, there being nothing in the situation of the spleen but a small hard mass. On these grounds, though no proper microscopical examination was made, I think there can be no reasonable doubt that this tumor was an enlarged movable spleen, the

very free range of mobility being due to the length of its pedicle. It may also be reasonably concluded that the first step in the production of the acute symptoms was *twisting of the pedicle;* the rapid increase in size, the acute congestion found when the exploratory incision was made, the numerous adhesions, and the subsequent destruction of the organ as noted in the history given, would naturally follow from the gradual strangulation of the circulation in the pedicle—*Am. Jr. Med. Sci.*, August, 1889.

Rice (E. P.) on Some Suggestions in Regard to Treating Gonorrhœa.—The author mixes boric acid 3 iii with glycerine ʒ i, and injects 3 ii of it by means of a soft rubber catheter and syringe into the urethra while the patient is in a recumbent posture. This injection he repeats daily for two or three days, and later, on alternate days. In long-standing cases he alternates its use with some mild astringent injection, and occasionally capsules containing bal. copaiva ♏vi and ol. cubeb. ♏iv t.i.d. The sound is sometimes used in subacute and chronic cases at intervals of about three days. As a rule, five or six treatments suffice.—*Med. Record*, July 20, 1889.

Mitchell (J. K.) on the Treatment of Seminal Emissions.—The treatment of cases of nervousness from masturbation, or more properly nervousness *about* former masturbation, is commonly not satisfactory, but there is one measure which has proved so useful in several cases under my care, that I think it worth while to note it that it may be tried by others. It was, so far as I know, originally suggested by Professor John H. Brinton some years since, and I believe has proved of value in his hands. It consists in the application of a blister over the sacrum.

The measure is a somewhat severe one, but the patients are apt to have suffered many things of doctors, from advertising quacks up, and various treatments, mostly of a depressing or a merely palliative sort, with small results, and I find they offer little objection. What is more, the improvement is usually lasting. Of course, the use of the blister need not preclude other and additional treatment, hygienic and medicinal.

The cases are, roughly speaking, divisible into two classes. One has emissions, usually during sleep, without erection or with only an attempt at erection; in the other, the semen is only voided during erection or upon some irritation, mental or physical. In the former sort, the treatment should be tonic. I like a mixture of dilute phosphoric acid and strychnia, which I generally give by the following formula:

℞ Strychniæ, gr. j.
Acidi phosphorici dil., f ʒ ij. M.
Sig.—25 drops in water after each meal.

In the latter kind, bromides, or better, a mixture of hydrobromic acid and bromide of soda or of lithium, have done me good service.

Of course, the usual precautions must be taken that no old stricture be left to keep up an irritation, and hygienic directions given—a hard bed, not too heavy coverings, light suppers, little meat, a sponge bath in the mornings, the bowels kept free, and all causes of sexual excitement avoided.

Many patients complain of passing seminal fluid with their water or at stool. I have yet to discover spermatozoa in the urine of any such persons, not at the time masturbators, and I believe that true spermatorrhœa must be a rare disorder. I have had no opportunity of trying the effect of blistering in this way upon a female masturbator.—*University Med. Mag.*, May, 1889.

Black (C.) on a Case of Self-Ablation of the Testicle.—A boy, æt. 19, came to me in my bedroom at six o'clock on the morning of the 11th May, 1888, informing me that he had "done something horrible to himself," pointing to the lower part of his body. On examination I found his shirt and other garments covered with blood, and the right testicle protruding from a circular and contracted wound in the scrotum, and with the cord more or less attached. A few minutes previously he had gone into his bath-room, deliberately placed the scrotum on the wooden ledge of the bath, and cut crosswise with a razor "down to the wood." There was very considerable arterial bleeding. He besought me to remove the testicle, and, seeing that the spermatic artery was cut, and the cord otherwise much injured, and that the bleeding could only be arrested by ligature, I controlled it in this manner and removed the testicle. The wound in the scrotum was stitched, and healed well in a few days. The reasons assigned for this extraordinary act

were that he had had nocturnal emissions so frequently, and he became so disgusted and depressed in spirits thereby. He had practised self-abuse for two years, and to this he ascribed the emissions. The act was that of a maniac, and most certainly for the time being the boy had brought himself into a maniacal condition. I saw the patient the other evening, and found him looking remarkably well. He has occasional involuntary nocturnal emissions and normal erections. In view of recent observations and experiences, I regret that the testicle was not available for Dr. Brown-Séquard. — *Med. Press*, July 10, 1889.

Hind (A. E.) on the Treatment of Hydrocele.—The treatment of hydrocele of the testis by injection of solution of perichloride of mercury was discussed, I believe, in the medical journals some years ago, but has not yet received the attention it deserves. In my hands it has always given complete satisfaction, but my cases have only been a limited number. I use a solution three times the strength of liquor hydrarg. perchlor., and first draw off the hydrocele fluid, and then wash out the cavity with the perchloride solution and draw off any remaining fluid. The last case on which I operated was an old double hydrocele with thick walls. The result was quite satisfactory. The injection does not cause pain, and is not followed by inflammation. In these respects it is superior to iodine. Its action depends on its power of forming an insoluble albuminate of mercury, by which the walls of the cavity are glued together. As far as my experience goes, there is no danger of mercurial poisoning. The albuminate is fairly insoluble, and a large amount of mercury is not required. I have tried this treatment with success in a case of infantile hydrocele after tapping had failed. Iodine causes pain when used, and often much pain afterwards by setting up more inflammation than is required to cure. Iodine also is not always efficacious, and may be followed by abscess. I believe perchloride is sure in its action, and its use does not necessitate rest in bed afterwards. —*Lancet*, July 6, 1889.

Johnston (J.) on a Gunshot Wound Disguised by a Stab.—An interesting case of murder has just occurred in Bradford, Pa. I wish to call your attention to it, to see if it has a parallel. A dissolute woman shot her lover in a drunken quarrel. The ball (.32 calibre) entered the left thigh at the middle of Scarpa's triangle; the man was sitting in a chair about ten feet from her at the time. She was alone with him in the room for some little time after, and, evidently to cover the shot wound, stabbed him to the bone. The external wound presented nothing different in appearance from a knife thrust, and the first autopsy revealed nothing more. During the progress of the coroner's investigation she changed her first story,—that he had stabbed himself,—stating that she had shot him in self-defense, and afterward "gone after" the ball with a case-knife, to get it out and save him. A second examination resulted in finding the ball.—*N. Y. Med. Jour.*, July 27, 1889.

Holt (R. C.) on a Case of Abdominal Tumor; Spontaneous Cure; Remarks.—A woman of thirty-nine, married, was admitted on Jan. 9, 1889. She was pale, and appeared to be suffering pain. Pulse 120; temperature 102°.

The woman complained of pain and tenderness in the abdomen, an examination of which showed a fluctuant tumor, of size and shape like a full-time pregnancy, only a little more inclined to the left side. The abdominal parietes were slightly œdematous. The position of the tumor near to the umbilicus was very distinctly fluctuating, but in the left iliac region it felt hard. The flanks were resonant. On vaginal examination, the vagina was found to be lengthened and pulled upwards and forward. In its posterior wall a rounded swelling could be felt, the nature of which it was impossible to make out. The os was high up, and almost out of reach, but could be indistinctly felt.

The patient stated that she was confined four years ago, and had never properly recovered her strength. She had been regular up to about four or six months before admission, when the catamenia had ceased, and then she noticed the abdominal swelling, which gradually increased. Three weeks before being seen she was seized with severe abdominal pain and elevation of temperature, which continued until her admission. She thought that the growth went on more rapidly after the attack of pain. The circumference one inch below the umbilicus was thirty-five inches. The temperature varied from 99° to 102.5°, which latter was the highest recorded; it

was taken on Jan. 22d, thirteen days after admission. It was decided to perform abdominalsection on the 23d. In the evening of the 22d she passed about one pint of blood-stained fæcal fluid per rectum. Up to this time the motions had been normal. On the morning of the 23d, the tumor being then present, she was prepared for operation, thirty-six ounces of pale urine being drawn off by catheter. When she was brought into the theatre and uncovered, the tumor had disappeared; the abdomen was resonant, and measured nearly the same as before; there was to be felt in the left iliac region a hard tumor, irregular in outline, about the size of a child's head; the pain had gone. She was put back to bed, and during that day and for the next five days passed about 300 ounces of dark-brown semi-solid material per rectum, which was examined and found to consist of altered blood cells and a quantity of what appeared to be ovarian cells. On the evening of the 25th, the temperature fell to 98.5°, and on that of the 26th it ascended to 102°, falling again in the morning. This variation continued for four days. The abdominal measurement on the 29th was thirty-two inches. She was kept in the hospital until Feb. 26th. The abdomen gradually lessened until it reached thirty-one inches. The tumor in the iliac fossa slowly disappeared.

April 3d.—Since Feb. 25th she has been at home, and has done her household duties. The abdomen measures twenty-nine inches, and is quite free from pain and tenderness. There is deep dulness in the right iliac fossa, and an oblique hernia has developed on the same side. Uterus and vagina normal in position. She has menstruated once.

This case appears to have been one of ovarian cyst, probably multilocular from the varying degrees of fluctuation. The peritonitis had evidently produced adhesion and ulceration into the bowel, and the opening must have been valvular, and spontaneous cure seems to have taken place. The most curious part is the disappearance of the tumor within so short a time before the operation. The probable explanation is that rupture had taken place the evening before, and that the nurse, in using the catheter prior to the operation, had exercised some pressure, and so partially emptied the cyst.—*Lancet*, June 29, 1889.

MISCELLANY.

Bacteriology of Green Sputa.—At a recent meeting of the Gessellschaft der Aerzte, in Zurich, Dr. Frick read a paper on the bacteriology of the green sputum, which is sometimes seen in cases of chronic bronchitis and pulmonary tuberculosis. According to his researches, which are based on a series of cases from a local hospital, the sputum invariably contains a peculiar chromogenic bacillus resembling in size and shape the typhoid bacterium, and elaborating a fluorescent green pigment matter both in artificial media and various sputa. The micro-organism is markedly aërobic and has a lively motility, but no pathogenic properties. The pigment originates in the medium, in close vicinity to the bacillus, which itself is colorless. The production of pigment, however, is not a vitally necessary function of the microbe, since by employing certain nutrient media, it proves possible to obtain a luxuriant growth without any trace of the coloring matter in the neighborhood. The substance is insoluble in alcohol, ether, or chloroform, but easily soluble in water and alkalies. The bacillus has no clinical significance, as it thrives in sputa of all possible morbid varieties.—*Br. Med. Jour.*, July 6, 1889.

Belt (E. O.) on Maggots in the Umbilicus.—Mrs. D. had been confined six days previously, and both herself and babe were apparently doing well up to the morning in question, when she noticed the child was somewhat jaundiced, which she said increased rapidly during the day. It soon became restless and refused to nurse. Bowels were quite free. Being quite poor, and sadly lacking in the belief that "cleanliness was next to godliness," both mother and child had received but little attention, and the child's umbilicus had not been dressed or looked at for two days. Charred linen had been used. Upon unwrapping the child the mother was horrified at finding a handful of maggots in and about the naval. When I arrived I saw perhaps a dozen, the size of chestnut worms, crawling over the child's abdomen, which the mother said came out of the umbilicus, where I could see a number at work. The funis had dropped off. The abdomen was red and swollen for an inch or two around. The feet and hands were purple, the rest of the body much jaundiced, and the child

looked as though it would survive only a few hours. Upon dropping in a few drops of carbolic acid and glycerine (1–4), at least a dozen more maggots came out of the umbilicus.

This seemed to give immediate relief, as shown by improvement in the cutaneous circulation and the child's wanting to nurse. A few small doses of calomel were ordered, and powdered chalk sprinkled over the navel. The icteroid condition passed off in a day or two. I saw the child again a few days ago, and found it in a very healthy condition, with no signs of trouble about the umbilicus whatever. It would be interesting to know how such a case might terminate without treatment, and the cause of the icterus. I think the latter was probably due to a beginning phlebitis of the umbilical vein.—*Maryland Med. Jour.*, July 13, 1889.

Fox (S. I.). Precocious Pregnancy.—I was called to see a case on June 30th. When I reached the house and went in the room, I saw a very small girl on the bed, and her mother said to me: "Doctor, my daughter miscarried on yesterday, and we wish you to take the afterbirth," which I did, and she is now doing well. When I was through, I asked how old she was, and father and mother both told me she was hardly twelve years old. Her father is a full-blooded negro, and her mother is a mulatto. —*Daniel's Texas Med. Jour.*, July 1, 1889.

Ulcerative Stomatitis.—According to Dr. Frühwald, ulcerative stomatitis begins on the external alveolar margin of the canines, appearing first as gingivitis catarrhalis. The gum becomes a pulpous mass, and salivation increases to an enormous extent, a very foul odor being produced. Gangrene of the soft parts and necrosis of the jaw-bones sometimes follow; glandular swellings are an ordinary symptom. Frühwald mentions the following predisposing causes of the disease: insufficient cleanliness of the oral cavity, naturally flabby gums, rachitis, scrofulosis, possibly climatic influences, certainly general affections, especially infectious diseases and scurvy, poisoning by lead, copper, mercury, and phosphorus. He recommends as treatment the application of iodoform or occasionally of nitrate of silver. He succeeded in cultivating from the discharge several kinds of micrococci and bacilli in gelatine and bouillion, and on potatoes, one of the species having a fetid odor. They are, according to Frühwald, undoubtedly pathogenic, producing fatal pleurisy and peritonitis in animals inoculated with them.—*Lancet*, July 31, 1889.

Pelvic Cellulitis in the Male Subject.—Dr. Skjeldrup describes, in the *Tidsskift for Praktisk Medicin*, the organ of the Norwegian Medical Association, a case, in a gentleman fifty years of age, which he diagnosed as pelvic cellulitis. The symptoms at first were vomiting, flatulence, constipation, abdominal tenderness, and tympanites, with pain over the cæcum, where there was some resistance on palpation and dulness on percussion. Rectal examination disclosed a tolerably hard tumor, which could be felt on bimanual examination to be situated in the left hypogastrium. An aperient powder was given, and quinine and iodide of potassium ordered five times a day, wet compresses being applied over the abdomen for some days. The patient's condition did not improve, the distension of the abdomen and the pain becoming greater, and the difficulty of passing flatus or fæces increasing; besides this, the patient was becoming more and more emaciated. With considerable difficulty an œsophagus tube was passed up to the sigmoid flexure, and was much bent by the tumor, which displaced the gut backwards; through this a warm injection was given, producing a scanty stool. Two days later the injection was repeated, a copious evacuation of very foul fæces resulting. After this the patient began to improve, and after a few more injections he was able to pass his stools naturally. At the end of a month there was only a slight amount of what felt like infiltration on the anterior aspect of the rectum to be detected. The diagnosis was one of considerable difficulty. The consistence of the tumor could not be satisfactorily made out, but sometimes it appeared to be firm, elastic, and somewhat tender. It was of an irregular shape, with no clearly defined limits. It was at first diagnosed by two medical men as a neoplasm of rapid growth; but the favorable termination shows that this was incorrect; so that, notwithstanding the rarity of pelvic cellulitis in a man, this seems to Dr. Skjeldrup the most probable explanation of the case. A case reported by Dr. Muir, of Selkirk, in 1885 is quoted by Dr. Skjeldrup as showing that cellulitis does sometimes occur in the pelvis of the male subject.—*Lancet*, July 28, 1888.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON DISEASES OF THE EYE.

BY A. T. MUZZY, M.D.

Martin (E.) on the Suture of the Cornea.—Dr. Suarez advocates this procedure in operations for cataract extraction. But it seems to us that instead of the advantages claimed, of perfect and permanent coaptation of the wound, better prospect of preventing prolapse or nipping of the iris, ability to dispense with the occlusive bandage, there are other sides to this procedure that make it really of no advantage, and in many cases of positive danger. The claim of 90 per cent. success gives it no precedence to old methods. Though an anæsthetic may control general sensation, yet there is always a certain amount of muscular spasm which generally does not disappear until after completion of the operation, and even the departure of the surgeon. The lengthening of the time of operation for this procedure and the strain upon the globe should rather heighten the liability of prolapse, and not only a prolapse of iris, but the stitching causes greater liability of rupture of the hyaloid and issue of part of the vitreous. Then foreign bodies in the healthy cornea, no larger than these minute-threads, readily and with astonishing rapidity set up suppuration.

Dr. Vacher, of Orleans, proves from actual experiments that this procedure retards the re-formation of the anterior chamber, but does favor setting up capsular adhesions and posterior synechiæ. At Vienna, where the suture has been tried for a long time, its results have been disastrous, producing prolapse of the iris, and suppurations either total or partial. Such is the balance of this operative complication, the first idea of which belongs to an American confrère, Dr. Williams.

As for us, we shall remain faithful to the *combined extraction* method by which we have during 20 years given useful vision to 94 out of 100.—*Rec. d'Ophthal.*, Paris, May, 1889.

Deeren. Some Observations on Methods of Artificial Ripening of Cataract. — Three cases of immature cataract in persons over 50 years of age were treated by a method very nearly the same as that described by M. Parisotti in the *Recueil d'Ophthalmologie* of March, 1889. Under cocaine anæsthesia a sclerotomy is performed two millimetres in length, and one or one and a half millimetres from sclero-corneal border, employing a lance knife: then by a buttoned stylet the aqueous humor is allowed to escape, so that the iris touches the cornea; then on the closed lids by the thumb massage is practised in all directions, vertical, transverse, and rotary; these frictions should have a regularly increasing force,—gentle at first and slowly but steadily increasing, the maximum force being relatively quite intense yet not harsh; the muscular power of the operator's thumb should be taken into account.

By this means as successful a result can be obtained as one may wish free from complications. After completing the massage I instil some drops of a one-per-cent solu-

tion of atropine to gain complete dilatation of the iris; then the eye is carefully bandaged.

The next day the wound will be cicatrized and the iris normal. The bandage is removed in 24 to 36 hours.

In the first case where I employed this method I did not succeed. In six weeks it was repeated with, this time, a good result; the fault, no doubt, being in the lack of sufficient force being used in the massage. But it may be that some incomplete cataracts may require one or more repetitions of this operation. It requires from six weeks to two months for the immature cataract to ripen, and it presents then a nucleus covered by a thin coating of grayish striæ. It is therefore a semi-hard cataract, and requires excessive care in clearing out, to gain a perfectly black pupil. Acuteness of vision will be just as good as after a naturally ripened cataract. M. Parisotti made an incision in his sclerotomy 6 millimetres long. I believe such an incision is in danger of producing prolapse of the iris.—*Rec. d'Ophthal.*, Paris, May, 1889.

Ayres (S. C.). Extraction of Cataract without Iridectomy.—In support of the brilliant results secured by Dr. Knapp, 32 cases of *simple extraction* of cataract are presented. In two cases accidents occurred independent of the surgical treatment, causing in one total loss of the eye. The resulting vision, taken ten days after operation, was one 0.7; two 0.5; four 0.4; two 0.3; eight 0.2; twelve 0.1; two $\frac{1}{10}$; and the remaining one a total loss. Strict antisepsis was carried out, Panas' fluid being used (hydrarg. biniodid. one part, alcohol 500 parts, water 20,000 parts); the patients' hands and face and conjunctival sac bathed and flushed; surgeons' and assistants' hands and all instruments. The difficult point of the operation is the handling of the cystotome. With competent assistance no blepharostat is necessary. The lens in escaping pushes the iris before it through the wound. And any cortical matter should be expelled now, as it is quite difficult to produce a prolapse of the iris without the assistance of the lens. The iris will generally replace itself spontaneously. If it does not, it is easily done by the spoon. A few drops of a solution of eserine are instilled; then cotton wet with Panas' fluid is laid over both eyes and held in place by a strip of isinglass plaster half an inch wide, reaching from eyebrow to cheek. The eye is inspected by the second or third day. There is often a tendency to iritis the second or third day, which is readily controlled by atropine. A liberal corneal incision makes the expulsion of the lens a very easy matter. This form of operation, *simple extraction*, is not advisable in over-ripe cataracts, nor in those complicated with posterior synechiæ or other complications.

The advantages, to my mind, of the operation are—soft cortical substance remaining behind will not endanger the result so readily with the iris to prevent its immediate contact with the corneal wound; and the injury done the iris in the *simple extraction*, when smoothly accomplished, is certainly less than in *Graefe's extraction* with iridectomy.—*Am. Jr. Ophthal.*, May, 1889.

Knapp (H.). Report on a Second Series of One Hundred Successive Cataract Extractions without Iridectomy—In the *technique* of the operation a 3-per-cent. solution of boric acid is substituted for Panas or $\frac{1}{10,000}$ bichloride of mercury, and only small quantities. In 25 cases the capsule was opened by the Graefe knife on its passage through the anterior chamber. In a few cases, though special care was taken, a few remnants were left. It did not interfere with smooth recovery and good vision in one. In six cases there was prolapse of iris; one only lost, due to undue amount of bichloride solution injected. Visual results were (on the day of discharge):

Primary.	Ultimate.
Good, 91 per cent.	Good, 97 per cent.
Moderate, 8 per cent.	Moderate, 2 per cent.
Failure, 1 per cent.	Failure, 1 per cent.

In the primary column there were no $\frac{1}{10}$ V. In the second were 30 cases. The gain between the first and second columns is due to discission of the capsule. I know this operation is delicate, requires precaution, judgment (passing the knife-needle through the places of least resistance and avoiding unyielding cords), good artificial light, perfect sight (a hyperopic or presbyopic operator should render himself myopic by a strong concave glass), and a sharp knife-kneedle which retains the aqueous. If I review my cases, the opinion is forced upon me that *the simple extraction is not only the best, but also the safest method of removing cataract.* The iris, spread out as a *velum interpositum* between the cornea section and

ciliary body, protects this, the most susceptible part of the eye, from deleterious substances that may enter through the wound. —*Arch. of Ophthal.*, New York, May, 1889.

Snell (Simeon). Glaucoma and Staphyloma Supervening Two Years and a Half after Scleral Puncture for Detached Retina.—A policeman, 43 years of age, came under treatment in December, 1885, for detachment of the retina at the outer and lower part. Vision of this eye, $\frac{10}{200}$, not improved. No cause assigned. Puncture was made by a Graefe knife through sclera between inferior and external recti. In February the puncture was repeated. Vision improved to $\frac{20}{70}$, and the detachment was less. In August, 1888, the patient reappeared, with acute pain and tension +2, with vision equal to perception of light. The sclera was staphylomatous at the site of puncture. Two weeks later the eye was removed, and showed a spindle-shaped mass, situated internally to the staphyloma, Microscopic character was that of inflammation, rather than of sarcomatous growth.—*Br. Med. Jour.*, May 11, 1889.

ON THE TREATMENT OF YELLOW FEVER.

Leaving aside the prophylaxis of yellow fever by preventive inoculation, as still of undetermined value and too dependant on a still uncertain pathology, the medicinal treatment of the disease is still in a very unsatisfactory state. Symptomatic treatment satisfies some; some depend on alkalies, others on acids, while all more or less favor the employment of germicidal agents.

Dr. Geo. Troup Maxwell's[1] plan is to make and keep the patients as comfortable as possible, opiates to relieve pain, gentle aperients when bowels are torpid, cool, but not cold drinks, and a hopeful frame of mind encouraged by cheerful surroundings. The disease being self-limited, he stands by as the friend of the patient, aiding defaulting organs, if possible, till the combat is ended. He has no cause to complain of results, having lost only 11 of a few over 200 patients. To be more specific his treatment:

1st. A hot foot-bath with mustard in it.

2d. A diaphoretic, perspiration to be kept up, but *no depletion*, as the patient will require all his nervous energy to recuperate, the fever being exhaustive.

3d. A purge of castor oil, and then

4th. Quiet and diet.

The alkaloid quinine and citrate of magnesia, with orange tea containing bicarbonate of soda, and sweet spirits of nitre are beneficial after the foot-bath where remittent fever is suspected.

Dr. Wolfred Nelson[2] first eliminates the possibility of a mistaken diagnosis of malaria, and also clears out the alimentary tract by the following prescription:

℞.—Sulphate of quinine . . . 3 i.
Dil. sulph. acid (B. Phar.) . 3 ii.
Sulphate of soda . . . . ʒ i.
Co. tr. cardamon. . . . . 3 ii.
Water to make . . . . . ʒ viii.

DIRECT.—Take a quarter at once and repeat in two hours.

This secures free movements of the bowels, and by its non-action on the fever eliminates the malarial element.

He then induces free diaphoresis by a hot-air bath and hot foot-bath, perhaps assisted by hot drinks. The full and free diaphoresis thus secured gives great temporary relief. Sinapisms to the epigastrium sometimes relieved the nausea and vomiting. During the remainder of the illness a solution of phosphoric acid is about the only medicine given.

Sternberg's[3] alkaline and bichloride treatment is as follows:

℞.—Bicarbonate of sodium . . . gr. cl.
Corrosive chloride of mercury . gr. $\frac{1}{10}$.
Water to . . . . . ℥ ii.

DIRECT.—About two ounces every hour to be taken *ice cold.*

The general mortality in the Decatur epidemic was 29.22 %; that of the whites 30.92 %. Under Sternberg's treatment the general mortality was 6.45 %, and among the whites 12.5 %. In the Jacksonville epidemic the cases treated by the alkaline method showed a mortality of 4.7 %. The general mortality was about 10 %.

The author considers the alkaline by far the most important part of the treatment, not giving the bichloride of mercury with the expectation that it will prove germicidal or a specific in the disease.

Corroborative of this statement is: Dr. Mitchell has reported a list of forty cases treated by the bichloride alone;

[1] *Va. Med. Mo.*, July, 1889.

[2] *Med. Record*, July 13, 1889.

[3] *Therapeutic Gazette*, May 15, 1889.

thirty-two of these were whites and eight colored; nine of the whites died,—a mortality of twenty-eight per cent.; whereas the mortality among the same class of patients treated by the alkaline and bichloride method was only 6.3 per cent.

Sternberg has but a single series of cases to report in which the bicarbonate of sodium was administered alone. These cases were treated at the "Quinta La Purissima Concepcion" by Dr. Duran. The formula used was: Bicarbonate of sodium, 6 grammes; sweetened water, 250 grammes. Of this mixture two tablespoonfuls were administered every two hours, or about 9 grammes (135 grs.) of the bicarbonate of sodium in the twenty-four hours. I have no information as to the character of the cases, or as to how long the treatment was continued. It often happens in the private hospitals of Havana that the patients, when brought to the hospital, have already been sick for several days, and the mortality is greatly influenced by this fact. In all, thirty cases are reported as having been treated by this solution, with eight deaths,—a mortality of 26.6 per cent. At the same time eleven cases were treated by the "antiseptic method," with six deaths,—a mortality of 54:5 per cent. The antiseptic administered was biniodide of mercury, 2 centigrammes, in 250 centigrammes of sweetened water,—two tablespoonfuls every two hours.

Both Mitchell and Sternberg, as a result of experience, recommended giving an increased amount of the alkali and adopt the following formula:

℞.—Bicarbonate of sodium . . .	3 iv.
Corrosive chloride of mercury .	gr. ½.
Water	O ii.

About 1½ ounces to be given *ice cold* every hour during the day and every two hours during the night.

Dr. Paul Gibier,[1] believing the disease to be an intra-intestinal bacterial affection, has a treatment of his own. For adynamic symptoms he gives strychnia and alcohol; when, and often before, renal symptoms appear, he employs measures to increase the activity of the skin.

The real and specific treatment of yellow fever, and therefore much the most important, is what he advises *from the first appearance of the disease.* Every morning give an active purgative. On the first day thirty-five to forty-five grammes of sulphate of soda; on the second day from forty to fifty grammes of castor oil; give it, if necessary, in two or three divided doses; on the third day give one gramme of calomel, and re-commence this course during a septenary. If the patient vomits a part of the dose, cause him to repeat at once with some small fragments of ice.

The author advises in addition the following:

No. 1.

℞.—Bichloride of mercury .	5 to 8 centigrammes.
Cognac	50 grammes.
Syrup acacia	50 "
Infusion of coffee . .	150 "

SIG.—One tablespoonful for a dose, given so that the whole formula will be taken during the twenty-four hours, using for the purpose glass or porcelain, not metal spoons.

No. 2.

℞.—Naphthaline, 0.50 centigramme in each wafer.

SIG.—Five to ten wafers during the twenty-four hours.

No. 3. Tannin can be used in the same way as naphthaline.

No. 4. Combat the thirst by a muriatic lemonade at one or two per 1,000.

Dr. L. C. Carr,[2] in the Jacksonvile epidemic, commenced by giving the patient four ounces of castor oil and a few drops of turpentine, and covers the patient with a blanket. He used much antifebrin, giving gr. v. every few hours. For drink he gave carbonated water, to which was sometimes added a little bichloride of mercury;—occasionally a diuretic.

Dr. John P. Wall,[3] of Tampa, equalizes the circulation by mustard pediluvia or baths, evacuates the bowels by some efficient but mild purgative, and controls febrile excitement by antifebrin and antipyrin. When the renal function fails he gives 10- to 15-drop doses of tincture of digitalis every two or three hours. He finds no remedy much relieves the nausea and hiccoughs. Hebersmith suggests[4] the hypodermic employment of pilocarpin in gr. ¼ doses, while Dr. W. H. Ford speaks[5] most emphatically in commendation of veratrum viride.

Dr. C. G. Comegys[6] advises that at the first sign of albuminuria the patient should

[1] *Gaillard's Med. Jour.*, March, 1889.
[2] *Am. Prac. and News*, Dec. 8, 1888.
[3] *Jour Am. Med. Assn.*, Nov. 17, 1888.
[4] *Med. Bulletin*, Nov., 1887.
[5] *St. Louis Cour. of Med.*, Nov., 1888.
[6] *Cincin. Lancet-Clinic*, Oct. 20, 1888.

be put in a bath of 110° and in a few minutes taken from the water and wrapped in blankets to help diaphoresis. A moderate purgation of calomel or blue pill should follow. Cool lemon- or orange-ade with a certain addition of acetate or bitartrate of potash, may be given liberally. An occasional dose of antifebrin or pilocarpin is allowable to aid diaphoresis.

In asthenic cases he uses digitalis and nitro-glycerine but avoids any alcoholic.

Dr. Wm. H. Holcombe, of New Orleans, La., in a lay contemporary says[1]:

"Some of the medical faculty have yet to learn that the moral treatment of yellow fever is vastly more important than the administration of drugs. The presence of a cheerful, hopeful, bright-spirited physician is more curative than quinine, calomel, or germicides. He needs an intelligent, quiet, reticent, good-natured nurse to aid him in his work. With good nurses, and doctors who studied mind as well as matter, and who trusted nature more than art—our sick-room would be bright and peaceful, cleanly and orderly in all its appointments, while fear would be dissipated, hope and courage inspired, and the safety of the patient already assured.

"The existence of disease should be ignored as much as possible. It should drop out from the papers, and be strictly tabooed in families as a subject of conversation. The business and amusements of the world should go on just as quietly and pleasantly as ever. To make a terrible bugbear of yellow fever and turn the attention of everybody to, and keep it fixed upon it, is a sure way to invite it, to propagate it, and to intensify it. He who labors to dispel fear from the public mind and from the chambers of the sick is the true benefactor in an epidemic. The noisy, officious philanthropist who is perpetually discussing the situation, suggesting specifics and forboding evil, is himself a mental miasm.

"The true sanitarian will remember in his treatment the tremendous power of words and ideas upon the sick. He will never indicate by his language, his looks or his conduct that he thinks the patient is very ill. He will cleanse his own mind of morbid fears and apprehensions, and reflect the stimulating light of hope on all around him. The suppression of anxiety and even sometimes of sympathy is necessary. His sickness should not be discussed before the patient, or any other cases of sickness alluded to. The doctor's opinion of the case should never be asked and never given within the patient's hearing. Erase, as far as possible, all thoughts of disease, danger, or death. The sick-room should not be darkened and made silent. It should be cheerful and natural, as if no sickness existed. It should have fresh air and cool water, and the fragrance of flowers instead of the odor of drugs. Hope and not fear should be the presiding genius of the place."

[1] *The Daily Picayune*, Oct. 22, 1888.

YELLOW FEVER IN BRAZIL.

An occasional correspondent of the *Journal of the American Medical Association* (July 27, 1889) writes that the yellow-fever epidemic of 1889 in Brazil has been of unprecedented severity, especially in the cities of Santos and Camfinas.

Santos is, after Rio, the most important of the coffee ports. A city of about 20,000 souls, situated just within the tropics, it is almost entirely surrounded by water; in fact, at high tide it is completely surrounded by the sea. The business part of the city is but little above the tides and is cut off from the sea breeze by Mt. Serrate, a high point within the city limits. Some years ago drains were constructed under the streets to carry off the rain-water, but there is no system of sewers. During the last few years permission has been granted to householders to connect their privies and house service with these loosely built mains. No precautions whatever have been taken in the way of tide flaps on the lateral pipes, so that the incoming tide, which flushes the drains of the lower part of the city, carries back the accumulated filth, forcing poisonous gases back into the tide drains. The soil has become thoroughly impregnated with fæcal matter, as the bricks at the bottom of the drains are laid without mortar. The city is supplied with drinking-water from the neighboring mountains, of excellent quality, but in quantity inadequate to the demands of the city. The present season has been noted for the almost total absence of rains, the heat has been intense and continued, for weeks and weeks, often reaching 36°C. in the shade and 54° in the sun. Under these conditions it is not strange that yel-

low fever should make its appearance, particularly as the streets and tenements of the city have been full of the poorest class of Italian immigrants for months.

On the 14th of January a man who had not been out of the city was seized with yellow fever and died. From this case and date the disease spread over the city. Several cases about this time were landed from foreign steamers, and were taken to the hospital and died, but it is true that the first case *was not imported and had not been in contact with foreign shipping*. Early in February the inhabitants began to abandon the city, so that during the height of the epidemic not more than 10,000 or 12,000 remained. The deaths in the city, so far as can be ascertained, from January 14th to date (May 28th) have been 1,238. This does not include those who died outside of the city, who had been exposed before leaving.

It is difficult to estimate the proportion of deaths to the number attacked. At one time at least one third of the whole population was prostrated with some kind of fever. As nearly as I could judge by visiting the hospitals and accompanying some of the most prominent physicians in their private practice during the height of the epidemic, about 40 per cent. of all the cases were different types of malarial fever.

The most striking feature of the epidemic both in Santos and Rio was the great frequency of sudden deaths, falling down in the street, becoming unconscious and dying in from two to eight hours. The native doctors call these pernicious attacks.

In the confusion and panic incident to an epidemic like the present one it is almost impossible to get at the real facts. The exact character of these cases has not been determined; whatever it may be it is clear that it is *not* sunstroke, as these cases are strictly confined to the places where yellow fever is epidemic.

In the public hospitals the death-rate was something fearful, probably 80 or 90 per cent.

So far as treatment was concerned, it was mostly palliative. The physicians are divided into three classes: those who give quinine in all cases, those who discriminate carefully between yellow and malarial fever and who never give quinine in the former, and those who treat symptoms only. In the Portugese hospital Dr. Furtado lost only about 10 per cent. of the yellow-fever cases. This physician does not use quinine in any stage, but after the preliminary treatment relies on alkalies and salicylate of soda, followed by perchloride of iron and iodine.

The disease at Santos and Rio has nothing particularly new about it, presenting about the same features as are found in the sweeping epidemics of our own country. But the outbreak at Camfinas is altogether new.

Camfinas is situated on the first plateau of Brazil, 700 metres above sea level and 160 kilometres from the coast in a straight line. It is somewhat lower than the range of mountains that separates it from the coast. The city is in a sort of basin surrounded on three sides by low hills. The population is estimated at 20,000. The houses are built without any attention to requirements of health, and in the poorer quarters crowded with Italian immigrants, six, seven, or eight families often occupying the same house. There is no attempt at drainage, each house having its own privy vault, often only a shallow excavation in the back yard in close neighborhood to the well. The cemetery is situated on the brow of the hill just above the town, and in the soft, porous earth it is fair to suppose that the wells get the full benefit of it. The heat in Camfinas is quite as intense as in Santos, the absence of rain more sensible because of the absence of the ocean or any other body of water. Under the old theory that yellow fever is a coast disease Camfinas would be safe from its ravages, but in spite of all theories it is true that it has this year been swept by the most destructive epidemic of yellow fever of which we have any account during the last half century.

On the 9th of February a German woman arrived in Camfinas from Santos with yellow fever and died in a Swiss bakery boarding-house. Within fifteen days the persons who slept on the mattress upon which the woman had died were taken sick and died also. The family nearly all died, and many of the customers of the bake-shop. About the same date a child was taken ill with what was supposed to be a bad type of bilious fever, in a house in which ten months before two persons had died of yellow fever contracted in Rio. The child died, and a competent physician pronounced it a case of genuine yellow fever. It is true, at all events, that other

members of the family were taken down and died. From these two points the disease spread in widening circles until new foci were established in different parts of the city, spreading in time to every corner of the place. Violent discussions arose among the physicians as to the real character of the disease—some classified it as typhus, others as the black plague, others as the ictero-hemorrhagic fever of the East. In the early days of the epidemic the clinical features of the disease were quite different from those of the fever raging in Santos: the temperature curves more abrupt, complete jaundice supervening on the second day, the thermometric record showing distinct intermissions, frequent cases of new invasion after entering upon a free convalescence, aphthous sores in the mouth, rapid pulse, violent delirium, etc.—still showing many of the characters of yellow fever: the suddenness of the onset, the lumbar pains, the flushing face, injected eyes, and redness of upper thorax, tendency to hemorrhage. Here and there, however, a clear and almost typical case of yellow fever was found. Very soon the large majority of the cases became unmistakably yellow fever. *Parri passu* with the development of the epidemic the ordinary malarial fevers began to assume a grave character, so that I would venture to say that 30 per cent. of the cases pronounced yellow fever were grave cases of remittent fever. I saw two such cases myself, both of which recovered, but one of which was attacked by genuine yellow fever afterwards. It was noticed that however severe an attack of either type, it conferred no immunity from the other.

The epidemic reached its climax in April. During this month there were 893 deaths out of a population of not more than 3,000. The death-rate among the poorer classes was something frightful. I saw in one of the small tenements seven persons sick on three beds, in a room without a window, all Italians recently arrived.

Now, while no one thinks that bad water filthy privies, or bad drains, create or spread yellow fever, as numerous striking cases might be cited to prove that the disease was in the air, and carried by the air or by some solid substance, such as clothing, etc., still the conditions created by these bad sanitary elements contribute in some way to its getting a foothold, *as under the same climatic influences*, the same conditions of heat and *absence* of moisture at the same altitude, the disease has not obtained a foothold whenever and wherever the sanitary conditions were good.

The city of São Paulo, being only 40 miles from Santos, and receiving nearly half of its population as refugees, many of them arriving with yellow fever and dying here, having besides 12,000 Italian immigrants, recently arrived in Santos, and brought here after exposure to yellow fever, and many of these with the disease already developed, crowded into close quarters, has not had a single case of yellow fever that was not brough there from Rio or Santos.

Why this immunity? You must pass through São Paulo to get to Camfinas. Why should this disease pass São Paulo with a population of 50,000, and make its headquarters in Camfinas and the cities beyond? It is because these cities are clean, well drained and well supplied with pure water, and, in the case of São Paulo, well paved with clean granite.

Dr. Domingos Freire came to Camfinas personally to superintend the inoculation of the people with his attenuated virus of yellow fever. Being obliged to return to Rio by the duties of his position, he left Dr. Angelo Simões in charge of the service. Up to the 7th inst., according to letter published, he had inoculated 630 persons, of *whom only three had been attacked*, and then in a mild form. The names and residences of these persons are recorded in the city offices, and are open for inspection and study.

In Santos, Dr. Barrata, a colleague and fellow professor of Dr. Freire, inoculated several hundred, chiefly among the foreign element, before the worst of the epidemic, and I am informed by reliable physicians, residents in Santos, that only a very insignificant number of those inoculated by Dr. Freire's method had yellow fever. These are significant facts in centres where, to escape an attack of the disease is the rare exception, and to have it, the rule.

Whatever may be said of the merits of Dr. Freire's attenuations from a scientific standpoint, these facts have a commercial significance not to be ignored. Whether he has found the microbe of yellow fever or not, or whether the fluid he injects contains the attenuated microbe or not, if it prevents yellow fever, or even if a large percentage of those inoculated escape in times of such sweeping epidemics as that of 1889, it deserves to be carefully investigated.

THE ETIOLOGY OF CANCER.

WITH ESPECIAL REFERENCE TO ITS CONTAGIOUSNESS AND MICROBIC ORIGIN.

Attention has been repeatedly called in these pages to this interesting subject, and the reader is referred to previous articles.[1] While nothing absolutely certain has been added to our knowledge of the subject of late, still there have been many investigators in the field, and their experiments are extremely interesting, if not conclusive. Among the most startling experiments is that of inoculation.

Dr. Hanau, of Zurich, at the recent Eighth German Congress of Internal Medicine, read a paper[2] on "The Artificial Inoculation of Cancer."

The experiments which have been undertaken up to the present, in regard to the transplantation of cancer, have given in some cases absolutely negative results, in others inflammatory alterations of a simple form; sometimes a true clinical tumor has been observed, the carcinomatous nature of which, however, is questionable. Two experiments only—one of Nowinsky, the other of Wehr—can be considered as having been successful, and yet no histological examination has been made.

In November, 1888, Hanau transplanted into the tunica vaginalis of the testicle of two rats, materials derived from non-ulcerated glands, but which were already involved by metastasis from a cancroid of the vulva which had spontaneously appeared in a female. One of those rats died seven weeks later; the post-mortem showed the presence of nodular cancer occupying the whole peritoneum; for we know that in the rat the inguinal canal is not obliterated.

In a second rat, sacrificed at the end of the eighth week, the tail of the epididymis was the seat of a cancerous nodule of about the size of a pea, and the gubernaculum testis presented a nodule about one thirtieth of an inch in diameter.

On histological examination, the identity between the structure of the tumors found in those animals and that of the cancerous material used was most striking. Both cases were of squamous epithelioma. The absence of any primary cutaneous cancer in those animals previous to his experiment, and the localization of the cancroid on the surface of the peritoneum or tunica vaginalis, allow him to establish a certain relation between the fact of transplantation and the production of the cancer. The failure of former experiments must be attributed to bad manipulation.

From the second dead rat, cancerous material was obtained and transplanted to a third animal, in which the existence of a tumor can already be distinguished.

From seven cases cited by Ledoux-Libard the following case of Langenbeck may be cited[3]: An encephaloid tumor, two hours after its removal from the humerus of a young man, was triturated in a mortar. The filtered juice was mixed with defibrinated blood from the femoral artery of a dog, and the mixture injected into the femoral vein of the same dog. The dog became very thin, and sixteen days later was killed. Two or three whitish tumors of the size of a lentil were found in the upper lobe of each lung, and in the middle lobe of the right lung a somewhat larger growth, which was hard and bled on section.

Microscopically, there was found in these tumors a connective-tissue stroma, through which were disposed "cancerous" cells, similar to, but larger than, those found in the original tumor.

It is not difficult to find good objections to such incomplete observations as that just cited.

Somewhat more to the point is the case reported by Gross,[3] of a woman who dressed a medullary sarcoma of an ox, and subsequently developed the same kind of tumor on the fourth finger of the left hand.

Klencke[3] inoculated a dog in the jugular vein, and a horse in the conjunctiva, with juice from a pigment carcinoma in a mare. In sixteen weeks the lachrymal gland of the horse had become converted into a melanotic tumor. The dog died in three months, and melanotic tumor masses were found through the lungs.

At the recent congress of German surgeons,[4] Mehr, of Lemberg, showed a dog dead from carcinoma following inocula-

[1] See MEDICAL ANALECTIC, 1886, p. 20, and 1888, pp. 41 and 432.

[2] *Med. News*, May, 1889.

[3] Christopher, *Cincin. Lancet-Clinic*, April 28, 1888.

[4] *La Pratique Méd.*, May 7, 1889.

tions from man. The peritoneal cavity was filled with tumors varying in size from a nut to an apple, the lymphatic ganglia were all infected, and the spleen showed some nodosities. Two other dogs which had been inoculated were shown living, and palpation revealed large nodosities on the abdominal wall.

Some important experiments have recently been undertaken by Hahn[1] in regard to cancer-grafting which are of considerable interest. They go to demonstrate that it is possible to inoculate with cancer-elements the skin of a patient beyond the part which is afflicted with the disease. The following details are published in connection therewith. A patient of the author's, who had been attacked with recurrent carcinoma of the left breast, which did not admit of surgical interference, had three small pieces of skin removed, in which cancerous infiltration was well marked. These were transplanted to the right breast. The grafts united, and two months and a half afterwards, when the patient died from the extension of the disease and the cachexia, a minute microscopical examination showed unequivocally the presence of carcinomatous elements in the right breast. In the opinion of the author this record proves that the transplantation of skin which is infiltrated with cancer can be followed by the development of the same neoplasm in a healthy part, especially in subjects who are predisposed to the disease. This emphasises the rule which obtains in regard to ensuring the complete removal of suspected tissues in the neighborhood of cancerous disease. In addition to this the author is disposed to believe that in many cases of recurrence, it is quite possible that the disease has developed anew as the result of accidental inoculation.

M. Maurice Denucé, of the Faculty of Medicine of Bordeaux, in an excellent review on the *microbe of cancer*,[2] cites some old instances of the apparent inoculability of cancer. He quotes Zacutus Lusitanus, "Praxis med. admirand.," lib. i., obs 124, as recording an instance where three boys developed cancer from having slept a long time with their mother, who had cancer of the breast. He also quotes Peyrilhe as quoting Tulpius, to the effect that a man, having sucked the cancerous breast of his wife to assuage the pain, was himself seized with cancer of the gums, and died.

Goujon (*Thèse de Paris*, 1886, *Jour. d'Anat. et de Physiol.*, 1867, p. 321, and *Soc. de Biologie*, 1867) inoculated a guinea-pig with a fragment of an epithelial cancer from another guinea-pig, with the result of finding in fifteen days a tumor the size of an almond at the site of the wound, and cancerous nodules in all the viscera.

According to Denucé the first recorded investigations as to the microbic origin of cancer were made by Rappin,[3] who, from scrapings from an epithelioma of the upper lip, obtained a pure culture of a diplococcus, which he also found in twelve other cases, both cancerous and sarcomatous. One rabbit which he inoculated with this culture, after various accidents, finally recovered, much emaciated, and covered with small ulcerations. It finally died at the end of three months, showing on autopsy remarkable nodules about the point of inoculation, 8 or 10 granules the size of millet in the liver, and a tumefaction of the mesenteric ganglia, which yielded pure cultures of the original diplococcus. The disappointing part of the story is that the experimenter later found the same microbe in benign tumors, colloid cysts of the breast, in healthy tissues, and in amputated extremities.

Denucé, after a careful study of twenty-six writers on the subject, concludes that, while malignant neoplasms are probably of an infectious and parasitic nature, the specific micro-organism has not yet been found.

Scheurlen, of Berlin, next after Rappin, announced the discovery of the bacillus of cancer.[4] With antiseptic precautions inoculations from the juice of ten mammary cancers were made on sterilized pleuritic fluid and placed in the incubator. In a few days a yellowish brown surface growth was found in a good proportion of the tubes. This consisted of a short bacillus, about 1.5μ to 2.5μ in length, and which could be readily stained by all the usual methods. The spores were more difficult to stain.

From the pure cultures of this bacillus he inoculated, with proper precautions, six

[1] *Med. Press*, Dec. 5, 1888.

[2] *Gaz. Hebd. des Sci. Méd. de Bordeaux*, Nov. 24, Dec. 9, and Dec. 23, 1888.

[3] *Gaz. Méd. de Nantes*, May and August, 1886, and "Researches on the Etiology of Malignant Tumors," Nantes, 1887.

[4] Matzinger, Concerning the Etiology of Cancer, *Med. Press*, West. N. Y., July, 1888.

bitches, by injecting some of the material into the hinder mammary gland. In fourteen days a soft swelling had formed in the gland, about the size of a walnut, which later became reduced in size and distinctly circumscribed. Two dogs were killed on the twenty-eighth and thirtieth day respectively, and in both was found a solid mass of the size of a bean, in which the microscope showed a collection of distinctly epithelioid cells, and in which both the spores could be distinctly seen. Pure cultures were again obtained from these specimens and corresponded exactly with the original one. The other four dogs were not killed, in order that further developments might be observed. From the constant occurrence of the spores in cancers, and the fact that by cultivation the bacillus always can be obtained from them, Scheurlen concludes that it must be the cause of cancer.

There is every reason for believing that this bacillus stands in some causative relation to cancer formation, and, as there is certainly no other way of accounting for it so reasonable and supported by as positive proof, it must be accepted as *the* cause of cancer.

This bacillus is easily stained by almost all the methods in the cancer milk or juice; the spores are difficult to stain, but can be recognized in the unstained specimen as glistening greenish ovoid bodies. In Dr. Park's admirably equipped laboratory Dr. Matzinger has also made inoculations on serum, agar-agar, and gelatine, from several specimens of cancer, but for some reason or other failed to grow the bacillus; in fact, failed to get any growth whatever. But he did succeed in growing a diplococcus from an epithelioma of the lip, which corresponds with the one described by Rappin. Later experimenters deny the connection of Scheurlen's bacillus with cancer, and say it often develops independently on potato.

Dr. Thoma, of Dorpat, in a recently published paper,[1] claims to have discovered singular microbic organisms in the epithelial cells of carcinomatous tumors. The observer found small cell-like structures in the epithelial nuclei of carcinomata, which differed so materially from all known kinds of cells that he felt compelled to classify them among the parasitic organisms. These microbes, for which thus far no pathogenic claim has been extended, are one-celled organisms measuring four to fifteen micromillimetres in diameter, and can be seen distinctly with the aid of hæmatoxylin, safranin, eosin, and alum-carmine. They consist of protoplasm and a nucleus, have a regular round or oval form, and show a strong refraction of light. Thoma has repeatedly seen them single or in clusters of four to six embedded in the epithelial nuclei of carcinomata of the breast, of the stomach, and of the intestinal tract. No pure cultures, nor other experiments which might serve to determine the exact nature of these microbes, have thus far been reported by Thoma.

Professor Kubasoff, of Moscow, claims[2] to have succeeded in demonstrating that cancerous neoplasms are caused by a special rod-shaped micro-organism, slightly ovoid in outline, and grouped in little heaps. Their total length is about one fourth the diameter of a red blood-corpuscle. Inoculation of animals with cultivations of the microbe gives rise to cancerous degeneration commencing in the adjacent lymphatic glands and spreading to the internal organs generally. Among the lower animals, rabbits and cats are most amenable to its effects, and they usually die in the course of two or three months with disseminated foci of cancerous nodules and cachexia. He inclines to the view that all cancerous growths are caused by the same bacillus.

Darier in Paget's disease finds[3] that, if epidermic scales from the diseased surface of the nipple be teased out in water or in iodized solution, either directly or after maceration in dilute ammonia or ammonium bichromate, there will be seen in the midst of the epithelial cells, and often within their interior, rounded bodies invested with a refractile membrane. These bodies are as large as, or even larger than, the cells, and their membrane contains either a single mass of protoplasm or corpuscular granules. They are constantly found in sections of the diseased skin at all levels of the epithelial covering, and also in the glandular prolongations of the epidermis. M. Darier affirms that they are of the nature of psorospermia or coccidia, and declares that they are to be seen in the offshoots of epithelioma of the nipple, that

[1] Correspondence of *Therap. Gas.*, July 15, 1889.
[2] *Medical Press*, March 27, 1889.
[3] *Prog. Médicale*, No. 16, 1889. Quoted in the *Lancet*, May 4, 1889.

they were figured by Butlin in 1876, and then regarded as evidence of endogenesis. The conclusion is that not only Paget's disease, but the duct cancer or epithelioma that is its sequel, may be due to the presence of this parasite, the detection of which, according to M. Darier, is a very simple matter.

According to the *Lancet*, June 8, 1889, a small commune in Normandy, Saint Sylvestre-de-Courcelles, with a present population of only 379, as compared with 500 twenty years ago, has in the eight years 1880–1887 lost no fewer than eleven of its inhabitants, between the ages of sixty-two and eighty-three, from cancer—a proportion of 15 per cent. of the total mortality. All but one of the cases were males, and in as many as eight the cancer was seated in the stomach. Such facts have led Dr. Arnaudet (*L' Union Méd.*, No. 52) to conclude that cancer is contagious, and is propagated through the medium of water. It is true, he remarks, that not one of the eleven persons mentioned were water drinkers, but then they drank cider, which is made with the pond water of the district. Dr. Arnaudet thinks this sufficient ground to advocate the use of antiseptics and of boiled water as prophylactics against cancer, as well as against typhoid fever or phthisis.

MISCELLANY.

Munn on Pelvic Peritonitis Caused by Violent Pressure on the Uterus Post-Partum.—The case related illustrates the probable and possibly frequent result of the injudicious use of Credé's method of completing the third stage of labor, and the injury that meddlesome midwifery is apt to inflict. The writer recently visited a woman in labor, for the purpose of removing a retained placenta. The women in attendance had made traction with the cord, and partially detached the placenta ; the woman was bleeding freely. Alarmed at her condition, he immediately placed his hands above the fundus of the uterus, and exercised what he thought was a proper amount of compression—what he supposed was the exact method of Credé. The hemorrhage was controlled promptly. He continued the pressure, and a moment later the hard ball, which could be felt in his hands, disappeared. Examining through the vagina, he felt a rounded tumor in the posterior cul de sac. He had exercised too great violence, and retroflexed the uterus. The patient progressed favorably. A week later, the patient was seized with all the symptoms of peritonitis. For two or three weeks, her death was daily expected. After that she made a slow recovery. For several months, she came to the office for treatment on account of pelvic pain. The writer could discover nothing but an erosion of the cervix, and this he treated, by the application of iodine and solutions of nitrate of silver. The thickening which resulted from the peritonitis, was so marked that he could necessarily make no positive diagnosis. Under general tonic treatment she regained a fair degree of health, but was never able to attend to her household duties and still suffered from pelvic pain. In the spring of this year the thickening in the pelvis had disappeared, so that it was possible to determine the exact condition. There was a dislocated ovary and tube. On the 13th of April, that is more than eleven months after the labor, the abdomen was opened and showed all the evidences of severe pelvic peritonitis. The right ovary and tube were prolapsed, the ovary itself was cystic, the pelvic peritoneum was covered with granulations. The ovary and tube were removed and she recovered. She is now able to do almost all kinds of household work, and is entirely free from pain. The author attributes the displacement of the ovary and tube, as well as the retroflexion and the pelvic peritonitis, to undue violence exercised by himself.—*Pittsburgh Med. Rev.*, July, 1889.

Total Extirpation of the Pregnant Cancerous Uterus.—In October, 1888, Dr. Zweifel, of Leipzig, removed a cancerous uterus in the sixth month of pregnancy. The operation was performed half through the abdomen, half through the vagina. First the patient was placed in the lithotomy position. The cervix was separated from the vagina, and Douglas' pouch opened by means of a Paquelin's cautery. The vagina was then packed with iodoform gauze. Then the patient was placed in the usual position for abdominal section, the uterus exposed and opened, and the child extracted. An elastic ligature was applied to the lowest part of the uterus, and the broad ligaments were tied above it. Then the uterus was cut away, and the vesico-uterine fold

opened. The abdominal wound being closed, the patient was once more placed in the lithotomy position, and the cervix freed entirely from its connections. Dr. Zweifel objected to leaving the wound open, as he had often seen intestine prolapse and adhere to dressings. He therefore closed the corners of the wound, and inserted a T-shaped gutta-percha tube. The patient recovered, convalescence being retarded by the formation of a large bedsore after an attack of gastric catarrh, with emaciation. The child was not saved. An abstract of the case appeared in the *Centralblatt für Gynäkologie*, No. 12, 1889. Total extirpation of the cancerous uterus, at term, has been performed twice by Schröder, with fatal results, and once by Bischoff, where the left ureter was tied, and the patient died. Sir Spencer Wells' case, performed at the sixth month, the mother recovering, occurred in 1881, and is well known to British surgeons.—*Br. Med. Jour.*, July 13, 1889.

Ward (S. M.) on a Case of Probable Absence of the Internal Organs of Generation in a Woman.—Miss B., twenty-two years old, consulted me some weeks ago for amenorrhœa. She was healthy in appearance, complexion dark, eyes and hair brown—*tout ensemble* purely feminine, no traces of masculinity in figure, voice or manner. In fact, she would attract attention on account of her personal charms. She had made an engagement of marriage, some months before, and not being satisfied with her physical condition, though assured by her mother that affairs would settle themselves after marriage, had clandestinely sought medical advice. She had never menstruated nor had any hemorrhage that might be construed as that function performed vicariously; neither had she ever had any symptoms that could by any possibility have been moliminal. Closest questioning on this point availed nothing, and she was too intelligent and too anxious for relief to have deceived me. What I did find out was, that until the present she had always congratulated herself on being spared the pain, trouble, and annoyance to which she knew her female friends were periodically subjected. External examination: mammary glands well developed and normal in appearance: hair plentiful in axillæ and on pubes; no enlargement of the abdomen, as in cases of retained menstrual blood; no trace of a uterus or ovaries by palpation; to sight and touch the external genitals were well developed and normal. There was no hymen, and no remains of one. The labia were perfect and well formed, but on separating them no trace of a vagina was found. Instead there was a *cul-de-sac*, corresponding in depth to the thickness of the labia. By accident the clitoris was touched during the examination, the patient thereupon showing some signs of excitement. Nothing was learned by the introduction of the finger into the rectum, or by bi-manual examination, *i. e.*, neither uterus nor ovaries were detected. Time was not given for anæsthesia to be induced, and for this reason no attempt was made to detect, through the rectal walls, a sound or catheter previously introduced into the bladder—a test I have seen recommended. My intention was to try this at her next visit, but I have unfortunately lost sight of her.—*Med. and Surg. Reporter*, July 27, 1889.

BOOK NOTICES.

Lectures on Bright's Disease. By Robert Saundby, M.D., etc. With fifty illustrations. 8vo. Pp. 290. Price $2.75. E. B. Treat, New York, 1889.

The author's attempt, according to his preface, is "to explain, within a modest compass, the present state of contemporary knowledge, making such additions and suggestions as have resulted from thirteen years' clinical and pathological study of *Bright's Disease.*"

The book comprises seven chapters on general pathology, one on the clinical examination of the urine in health and disease, while section III deals with Bright's disease strictly; there being chapters on history, classification, etiology, general anatomy of the kidney, febrile nephritis, lithæmic nephritis, obstructive nephritis, and complications of chronic Bright's disease, with a concluding chapter on the treatment of lithæmic nephritis. A general index of authors and subjects follows. The illustrations are numerous and good, the print large and clear, and the subject-matter of the book up to date and satisfactory.

Transactions of the Congress of American Physicians and Surgeons.—First triennial session held at Washington, D. C., September 18, 19, and 20, 1888. Published by the Congress. New Haven, Conn., 1889. Press of Tuttle, Morehouse, & Taylor, New Haven, Conn. Large 8vo, pp. 386.

The greater part of the contents of these Transactions has already appeared in print and requires no comment. The chief subjects discussed were the treatment of acute intestinal obstruction, medical and surgical, cerebral localization and surgery, and a long paper on Medical Museums.

The Transactions make a handsome volume, a credit to the association from which it emanates.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON DISEASES OF THE NOSE AND THROAT.

BY CHARLES H. KNIGHT, M.D.

Schuchardt (K.) on the Nature of Ozæna.—The author has found in a large number of cases a transformation of the cylindrical epithelium of the nasal mucous membrane into pavement epithelium. The membrane is devoid of glands and is converted into granulation or cicatricial tissue, constituted by ten or twelve layers of pavement epithelium which decomposes and becomes a source of danger, since the development of cancroid is by no means uncommon under these circumstances.—*Med. News*, June 1, 1889.

In the treatment of ozæna Ruault obtains the best results from applications of pledgets of wool moistened with camphorated naphthol in vaseline, after thorough cleansing and removal of crusts. —*Arch. de Laryngol.*, etc., April, 1889.

In this connection a paper by Jonathan Wright, on "Nasal Bacteria in Health," is of interest. A series of ten observations give instructive results. The original should be consulted.—*N. Y. Med. Jour.*, July 27, 1889.

Gluck (J.) on Membranous Rhinitis.—The author refers to Potter's observations (*Jour. of Laryngol., and Rhinol.*, March, 1889), and in his own cases claims to have had superior results with local applications of atropine. It seemed to act as a sedative, caused contraction, and checked exudation immediately.—*Med. Record*, N. Y., April 27, 1889.

Hall (F. de Havilland) on Hay Fever and Hay Asthma.—The author subscribes to the three great factors concerned in the evolution of hay fever as enumerated by Sir Andrew Clark, namely: (1) a nervous constitution or idiosyncrasy; (2) local irritability, involving the nervous, vascular, and cellular structures; (3) external exciting or determining causes, such as the pollen of various grasses. In the matter of treatment he thinks most highly of the galvano-cautery. In nearly every case a condition of hypertrophic rhinitis exists, or there may be a limited area of puffy swelling on one of the turbinated bodies or septum. This should be thoroughly cauterized with a fine galvano-caustic point, after the parts have been anæsthetized with a 20 per cent. solution of cocaine. The habitual use of cocaine is decidedly objectionable, since it eventually aggravates the evil it was meant to cure.—*The Lancet*, London, June 15, 1889.

The galvano-cautery is strongly recommended by Dr. A. Bronner in what he calls "pseudo hay fever," characterized by hypertrophic changes in the mucous membrane, in distinction from the simple neurotic form, in which no structural changes can be detected.—*Brit. Med. Jour.*, March 23, 1889. *The Lancet*, London, July 13, 1889.

Illingworth recommends nasal douche and sprays of biniodine of mercury, 1 to 2,000.—*Brit. Med. Jour.*, Nov. 3, 1888.

Runalt, in opposition to views recently

propounded in France by Leflaive and Lermoyez, advocates the neurotic theory of hay fever, and, while admitting the impossibility of always discovering a cause, maintains that the disease is most common in those affected with hypertrophic rhinitis, and in gouty or neurotic persons or in those having antecedents of this character.—*Arch. de Laryngol.*, etc., March and April, 1889.

Hinkel (F. W.) on Some Manifestations of Lithæmia of the Upper Air-Passages.—The influence of lithæmia and allied conditions upon the upper air-passages has received little attention in laryngology, as is shown by the scanty literature upon the subject. There is a distinction between gouty sore-throat and that due to lithæmia or some allied condition. The subjects of the latter may never have attacks of true gout, nor irregular manifestations of it—indeed, as a rule, they are not so affected. Its manifestations in the upper air-passages are not sharply distinguished, nor are they typical or pathognomonic. One of the most characteristic is a patchy or streaked irregular congestion of the mucous membrane of the larynx and pharynx. In the former case a dry explosive cough accompanies,in the latter uneasiness or positive pain is referred to the side of the throat, occasionally extending to the ears. These cases are notably irritated and made worse by stimulant applications. Local sedatives and general antilithic treatment give the best results. Occasionally acute naso-pharyngeal catarrh is a manifestation of an exacerbation of the lithæmic tendency. Alkaline and diluent medication with proper diet give more relief than local treatment. Obstinate relaxation of the nervous plexuses of the turbinated bodies in some individuals appears associated with lithæmia. Such cases stand operative—caustic—applications badly and receive little or no benefit from them.—*Jour. Am. Med. Ass'n*, June 22, 1889.

The Med. Press, July 13, 1889, contains a discussion on "Gouty Sore-Throat" at the meeting of the Br. Laryngological Ass'n, opened by Sir Morell Mackenzie, who admits its existence under two conditions: 1. When an acute throat affection suddenly disappeared upon the supervention of well-marked gouty manifestations elsewhere. 2. Obstinate affections of the throat in persons who were manifestly gouty, and those cases in which local treatment directed to the throat had failed to afford relief, but which yielded to constitutional treatment for gout.

Casselberry (W. E.) on Nasal Myxomata.—This paper is an excellent resumé of this important subject. It contains nothing new, except the report of several cases, and the description of a new saw, so curved as to permit its easy introduction beneath those very common septal ridges which lie close to the floor of the nose. It also has the advantage, by the arrangement of its teeth, of cutting only on the *pull*. Ordinarily we cut with a straight saw from above downwards, but the instrument is apt to slip, unless the ridge is very abrupt.—*Jour. Am. Med. Ass'n*, March 16, 1889.

Mackenzie (J. N.) on Some Points in the Pathology and Treatment of Diseases of the Nasal Pharynx.—

1. The nasal pharynx is, in quite a large proportion of individuals, exceedingly sensitive to reflex-producing stimulation.

2. The areas chiefly involved are the posterior portions of the turbinated erectile tissue, and various points along the upper and posterior portions of the nasal pharynx.

3. In consequence of this extreme sensitiveness, a local pathological process which in many persons would give rise to no reflex neuro-vascular changes, may awake a host of neurotic phenomena, referable not only to the region primarily involved, but also to other and even remote organs of the body. These may include cough, asthma, and various neuralgic affections; or the local structural lesion may be the starting-point of various sympathetic affections of the respiratory tract.

4. That these classes of naso-pharyngeal neuroses are explicable on the same general principle laid down in the article on neuroses of the nose; and the pathology of the nasal and post-nasal affections is therefore one and the same.

5. That the treatment should be carried out according to the general directions laid down in the article just mentioned.

6. That when morbid processes originate in the pharyngeal tonsil attention should not be directed to the bursa alone, but an endeavor should be made to extirpate the tonsil as far as possible in its entirety.

7. That while a favorable prognosis cannot be safely predicted by treatment of the bursa alone, extirpation of the pharyngeal

tonsil often affords a most favorable prospect in long-standing cases of post-nasal trouble.—*Boston Med. and Surg. Jour.*, June 20, 1889.

Browne (Wm. H.) on a Case of Salivary Calculus; Removal.—The unusual youth of this patient, eight years, gives interest to the case. The calculus, which was the size of a small bean and weighed a little over seven grains, was removed by slitting up Wharton's duct.—*The Lancet*, London, May 25, 1889.

In the *Br. Med. Jour.*, April 27, 1889, F. W. Clark describes a case of calculus occupying Wharton's duct, of which symptoms had been present for more than four years. The concretion weighed five grains.

In the *Br. Med. Jour.*, May 18, 1889, a case is narrated in which Wharton's duct was dilated by two calculi, both together weighing nine grains.

Howard (B.) on a New and Only Way of Raising the Epiglottis (*Br. Med. Jour.*, Nov. 17. 1889). **Foulis (James) on the Only Way of Raising the Tongue, the Epiglottis, and the Aryteno-Epiglottic Folds at One and the Same Time** (*Edinb. Med. Jour.*, July, 1889).—Each of these papers is an interesting and valuable contribution to this subject. Briefly, the former method consists of extreme extension of the head. Foulis admits the value of the common practice of dragging out the tongue, but in some cases this will not suffice, and the lower jaw must be drawn forward by hooking the finger behind the incisor teeth and by the use of his instrument, which he calls the "glossotilt."

In the *Jour. of Laryngology and Rhinology*, June, 1889, may be found an important paper by J. F. W. Silk "On Position and Methods of Anæsthetization in Naso-Pharyngeal Operations," which contains many practical suggestions regarding the choice and use of anæsthetics.

Glasgow (W. C.) on an Œdematous Form of Disease of the Upper Air-Passages. — The paper described an œdematous form of disease which had been epidemic around St. Louis for some two years. In all cases of this disease there is found a pale, œdematous condition of the fauces. This is a solid œdema. A peculiar glistening appearance is at times very marked. In the majority of cases the soft palate is the seat of the œdema. At times the nasal mucous membrane is found in the same condition. The epiglottis and different portions of the larynx may be involved. In some cases the true cords are markedly œdematous. A swollen condition of the veins, particularly the palatine veins, is present. This sometimes causes purpura-looking spots, and the mucous membrane appears mottled. In two cases these purpura-looking spots had been seen in the trachea. In one case enlarged veins were seen on the true cord. In some cases ulceration occurs. In some cases, in addition to œdema, there were patches of exudation in different parts of the throat. These, when removed, leave a bleeding surface. The symptoms of the disease and the appearance of the throat preclude the diagnosis of diphtheria. In six cases spots of mycosis were seen. Glandular enlargement of the neck is quite frequent. In two cases suppuration occurred.

The symptoms are constitutional and local. The affection occurs suddenly in persons of previous good health. There is languor and weakness and general pains throughout the body. Headache is present, usually frontal, sometimes occipital. In many cases it is simply a dull heavy feeling; in others it is an intense, violent, throbbing pain. Pain in the back, in the region of the sacrum, is a characteristic symptom. Fever is present in varying degree. In the exudative cases the disease commences with chill, followed by fever, and the temperature may reach 105°. This soon passes off, and we have a sub-febrile condition remaining, possibly with a temperature of 101°. This continues a short time and then there is a return to the normal temperature. When there is simply œdema, the temperature scarcely ever rises above 101° or 102°. This remains for only twelve hours, and during the remainder of the attack the temperature is normal. The pulse is always rapid, soft, and compressible. There has been no exception to this noted. The pulse ranges between 90 to 110 per minute. Profuse sweating is often present, especially during the night. It may be localized.

The local symptoms vary with the part of the throat involved. Sometimes they are prominent, sometimes they are wanting. Hemorrhages are common. They are usually slight but recur frequently.

This is a constitutional disease, due, the author believes, to some change in the blood, exactly what he was unprepared to

say, but probably due to micro-organisms. He thought that the disease described was nothing more than influenza, the same influenza which has been described so often, particularly by Graves. The disease has not been limited to the Mississippi valley, for the speaker had seen cases of it from all parts of the country.

The treatment is very simple. The system must be saturated with benzoate of sodium. Under this remedy the affection subsides in a few days or hours. If left to itself it may continue for weeks and even months.—*Boston Med. and Surg. Jour.*, June 13, 1889.

Seiler (Carl) on Clinical Observations on Some Cases of a Peculiar Character.—The run of symptoms of the cases observed by the author was summed up as follows :

1. Neuralgic muscular pains, usually in the back and chest, and often in the head, ears, and limbs.
2. Extreme debility.
3. Mucoid infiltration of the submucous tissues, and the formation of thin, white, pseudo-membranous patches on the surface of the mucous membrane.
4. Absence of febrile symptoms at first ; and later, high temperature and low rate of pulse relatively.
5. Absence of albumen in the urine, and liability of heart failure.
6. Gradual melting away of the pseudo-membrane, and the absence of any odor from it.
7. The wide geographical distribution in this country, and the infectious but not contagious nature of the disorder.
8. Finally, the specific action of benzoate of soda in relieving the symptoms promptly. —*Med. Record*, N. Y., July 6, 1889.

Potter (F. H.) on the Use of Menthol in the Upper Air-Passages.—The results indicate that the drug controls superficial inflammation ; that it is an analgesic, and a second application may be made of greater strength without discomfort ; that it is destructive of some low forms of life, especially the bacillus tuberculosis ; and that it is a valuable antiseptic in nasal surgery. It has an important place in the treatment of atrophic conditions. It can be used in strength of from one to fifty per cent. dissolved in oil. The oleum petrolei the author considers the best for the purpose of dissolving the drug. It may be applied directly by cotton application, or by means of the spray, or by vaporization. The direct method answers best in the pharynx, the spray and vapor for the nose and larynx. Five cases of laryngeal phthisis following upon disease of the lungs were also reported, in which the menthol treatment gave satisfactory results, the local conditions improving rapidly under its use.—*Med. Record*, N. Y., July 6, 1889.

Knight (C. H.) on Menthol in Laryngeal Phthisis.—Twenty cases, most of them of a severe type, treated with menthol applications, furnished the author ground for believing that this is a valuable agent in tubercular laryngitis. The drug was dissolved in fluid albolene in the proportion of a drachm or a drachm and a half to the ounce, and applied by means of a laryngeal syringe, or in the form of spray by a nebulizer or vaporizer. In nearly all cases the subjective symptoms and the local appearance improved. In no case did complete healing of an ulcer take place. In this respect the author's experience does not bear out the representations of Rosenberg and others. Three propositions are offered : (1) Spontaneous cure of a tubercular ulcer of the larynx may occur ; (2) a simple erosion or ulceration may be mistaken for a tubercular ulcer ; (3) the best results from local treatment of the larynx may be expected in cases of incipient or limited pulmonary disease and in primary laryngeal tuberculosis. — *Med. Record*, N. Y., July 6, 1889.

Issendovsky concludes that : (1) Menthol is a good anodyne, securing a considerable, though temporary, subjective amelioration ; (2) it is useful to administer the drug simultaneously externally and internally ; (3) the best plan is to begin the painting with a ten-per-cent. solution, and gradually pass to stronger ones. A forty- to fifty-per-cent. solution gives rise occasionally to an intense local reaction.—*Jour. of Laryngol. and Rhinol.*, June, 1889.

In the *Maryland Med. Jour.*, May 25, 1889, Dr. McSherry speaks highly of menthol in laryngeal phthisis.

The lactic-acid treatment and the comparative value of menthol and the acid are discussed by Golynetz, Blumenau, and others in papers abstracted in the *Jour. of Larnygol. and Rhinol.*, June, 1889.

Krause has recently given additional notes on the use of lactic acid to which he adheres.—*Med. News*, June 1, 1889.

Whipham and Delepine on Tubercular Lupus of the Larynx, Trachea, and Bronchi, Producing Stenosis of the Trachea and Bronchi.—This very interesting and unusual case, which is described in detail, seems rather to have been a combination of syphilis and tuberculosis, of which we have recently had several examples reported. Tubercle bacilli were not found in the tissues, possibly because of prolonged immersion of the specimen in chromic acid, but there were manifest signs of disease at the left apex and the appearance of the laryngeal ulceration leaves but little room for doubt as to its character. The marked features suggesting syphilis were the presence of submucous infiltration and excessive formation of cicatricial tissue, while on the other hand there was extensive atrophy and destruction of the submucous glands.

The post-cervical glands, however, were enlarged, and lesions were developed in the fauces and in the nose which were clearly specific.—*The Med. Press*, March 13, 1889.

Brown (Dillon) on Intubation of the Larynx in Diphtheritic Croup.—The author has operated upon two hundred patients with diphtheritic or membranous laryngitis, of which fifty-four, or twenty-seven per cent., recovered:

Males, 87; females, 113. Average age, 3 years 5 months; of those that died, 3 years 2 months; of those that recovered, 4 years 5 months.

Urine contained albumen in 116 cases, no albumen in 15 cases, and was not examined in 69 cases.

In fatal cases, average length of life after intubation was 2 days 23 hours; in cases of recovery, average time of tube in larynx was 5 days 10 hours.

Tables are given showing the relative number of deaths from various causes, the percentage of recoveries according to duration of laryngeal symptoms, and of pharyngeal or post-nasal diphtheria before operation became necessary, as well as the percentage according to age and for each month of the year. A list of 2,368 cases gives 647 recoveries, or 27.3 per cent.—*N. Y. Med. Jour.*, March 9, 1889.

In the *Canadian Practitioner*, March 1, 1889, Dr. L. L. Palmer mentions having had nineteen cases with five recoveries. He strongly advocates operative interference in laryngeal diphtheria.

In the *North American Practitioner*, March, 1889, Dr. F. E. Waxham gives a full description of the operation and of the after treatment. He regards intubation as more difficult than tracheotomy, but he recommends it at *all ages*, under *all conditions*, and under all circumstances.

Annandale (T.) on Intubation of the Larynx and Air Passages; with a Description of a New Instrument as an Aid to Certain Operations.—The new instrument is a tube, not too pliable, shaped after Schroetter's, intended to be passed through the mouth, having an arrangement to prevent its compression by the teeth or otherwise, and having attached to it a piece of india-rubber tubing, so that the anæsthetic may be administered from a distance.—*Brit. Med. Jour.*, March 2, 1889.

In the *Med. Record*, July 27, 1889, Dr. A. Brothers reports a rather interesting case of intubation.

Gerster (A. G.) on Removal of a Tubercular Tumor of the Larynx by Laryngo-Pharyngotomy.—This case is of unusual interest, because of the variety of the lesion and its successful removal, and also for the reason that the method of operating was new, the danger of the operation and the subsequent risks being thereby diminished. The author refers to the well-known paper of Hennig, who could find reported only six cases besides his own of circumscribed single or multiple tubercular tumor of the larynx. The operation was performed as follows. A high tracheotomy was done and a tampon canula inserted. A median incision, including the cricoid and thyroid cartilages, was found to give less room than desirable; so a second incision at a right angle was carried outward through the thyro-hyoid membrane parallel to the hyoid bone. Thus the tumor was freely exposed and its complete removal was easy. A small portion of the posterior extremity of the left vocal cord, together with the arytenoid and a corresponding segment of the thyroid cartilage, were also excised. The pharyngeal wound was closed with three rows of superimposed buried catgut sutures, the first or deepest stitches being passed close to but not through the mucous membrane. It healed by first intention. The laryngeal wound was dusted with iodoform and packed with gauze to the situation of the tracheal canula. Six silkworm-gut sutures were passed, one including the thyroid cartilage,

their ends being secured by split shot. Externally an antiseptic dressing was applied, leaving exposed the aperture of the trachea tube. This wound healed, leaving a fistula, which was afterwards closed by a plastic operation, based on Szymanovsky's plan of closing perineal fistulæ of the urethra, consisting essentially of the superimposition of two semilunar cutaneous flaps. The tumor, which was the size of an unshelled almond, was characteristic of tuberculosis, showing lymphoid structure, giant cells, and tubercle bacilli. A repetition of this operation in a similar case is not to be expected, even though it may be good surgery. The author concludes his report in the following words: "Whatever may be the ultimate issue of the case, so much can be safely claimed, that an earlier excision might have accomplished just as much, if not more, than the operation performed in October; that thereby the distressing dysphagia and dyspnœa were successfully removed, which tracheotomy alone could not have accomplished; and that excision has inaugurated a decided improvement in the patient's general condition; that the extension of the pulmonary process cannot be justly charged to the performance of the operation; and finally, that a prolongation of life, as well as a material mitigation of the sufferings of the patient, can be readily assumed to have been secured."—*N. Y. Med. Record*, April 6, 1889.

White (W. P.) on the Retention of a Foreign Body in the Air Passages for Seven Months.—The foreign body in this case, "a head of herd's grass or timothy," caused no trouble except slight cough for two weeks, when a pulmonary abscess developed, attended by extreme constitutional disturbance. The abscess discharged itself freely, but the foreign body did not appear. Yet the condition of the patient slowly improved. Cough continued, and there were several attacks of hemoptysis, until seven months after the accident, during a violent fit of coughing, the blade of grass was expectorated. Complete recovery followed.—*Gaillard's Med. Jour.*, July, 1889.

In the *Br. Med. Jour.*, March 23, 1889, a fatal case is reported, that of a child three years old, the foreign body being part of a plum-stone swallowed four months before. The importance of early tracheotomy is noticed.

In the *London Lancet*, March 16, 1889, the remarkable case reported by Pieniçzek is referred to. Here the foreign body was a caoutchouc tracheotomy tube, which remained in the bronchus nearly seven weeks. Its position was determined and its removal greatly facilitated by the use of a laryngeal mirror passed into the tracheal opening. (See also *Arch. für Kinderheilk.*, B. xii., 5.)

In the *Pittsburgh Med. Review*, July, 1889, Dr. Rigg reports a case in which a small piece of bone appears to have been retained somewhere in the lower air-tract for nearly thirteen months. By the time of its dislodgment and removal, extensive and permanent damage had been established in the lung.

In the *Med. News*, April 13, 1889, Dr. H. R. Wharton gives an interesting "report of a case in which a large-headed brass shawl-pin remained in the trachea for ten days, and was removed seven hours after tracheotomy. Profuse hemorrhage from the trachea and expulsion of a large number of fibrinous casts." The paper contains some valuable hints regarding the management of these cases.

Jalaquier reports a case in which an almond was removed by tracheotomy.—*Jour. of Laryngol. and Rhinol.*, June, 1889.

OCCASIONAL REPORT ON INSANITY.

BY FREDERICK PETERSON, M.D.

Manning (F. N.) on Lunacy in Australia.—An analysis of the statistics of insanity in the Australian colonies shows that there is one insane person to every 349, or 2.86 per 1000. This ratio is somewhat less than that of the United Kingdom, where it ranges from 1 in 316 in Ireland to 1 in 346 in England. This comparison is based upon data complete to New Year's, 1888. The author finds insanity on the increase in Australia in proportion to the general population, but considers the increase due altogether to accumulation of chronic cases. He also discusses a question which is interesting to American alienists also, viz.: the nationality of the insane. It seems that only 23.12 % of the insane are native Australians. Ireland contributes 26 %, England 23 %, Scotland 6 %, Germany 2 %, and China 2 %.

The death-rate in Australian asylums is smaller than that of England, which the

author believes to be due to the warmth and equability of the climate of his country, rendering the patients much less liable to pneumonia and other chest affections, which prevail in English asylums.

General paralysis seems to be much less frequent in Australia than in England. The proportion of cases admitted to asylums suffering from this disease to the whole number admitted is only 1.8 % in the former country, but 8.6 % in the latter. Epilepsy is decidedly less common in Australian than in English asylums.

In the provision of reception houses in New South Wales and Queensland, and of lunacy wards in public hospitals in Victoria, for the treatment of insanity in its early stages, the Australian statutes are decidedly in advance of those of Great Britain, and, the editor may add, also in advance of those of the United States.

There has been little legislative provision for imbeciles and idiots in Australia, and most of cases find a place of refuge in the ordinary insane asylums, but New South Wales has a separate hospital for idiots. Three of the colonies have institutions for insane criminals.

Restraint is the exception in asylum treatment, but appears to be used on an average in one out of 300 or 400 cases, and then chiefly for surgical reasons or to prevent suicide.

The author very sensibly says that no one form of building can meet all the requirements of the insane, and his ideal Psychopathic Hospital is one that certainly would meet the approval of all who have had experience in the management of large numbers of the insane. He would stipulate for a central hospital for the sick and for acute cases, surrounded by blocks or pavilions of varying form and construction for different classes, and supplemented by cottages for the convalescent, the quiet, and for certain chronic cases. At least a fourth of the total accommodation should be in the form of separate or single rooms. The pavilions should be comparatively small, so as to prevent too large an aggregation of patients.

As regards the criminal insane, he thinks that those who commit crimes while insane should be treated in asylums, but that there should be lunacy wards in prisons, just as there are sick-wards for those who become insane while undergoing penal servitude, and refers to the successful administration of lunacy wards in connection with the Scotch prison at Perth, and with the English prison at Woking.

It is interesting to learn from Dr. Manning that the universities of Sydney and Adelaide make the study of psychological medicine a compulsory part of the curriculum for degrees.—*Australasian Med. Gazette*, Jan., 1889.

Howden (J. C.) on the Treatment of Insanity.—The views of the author upon this subject, who is the superintendent of the Montrose Royal Lunatic Asylum, are well worth reading. Some of them are here briefly presented. He thinks it wrong to belittle the possibilities of brain surgery as applied to insanity. Cases are already on record of the cure of insanity by the removal of a depressed piece of cranial bone, although few cases would manifest such surgical simplicity. Epilepsy, however, is a prominent factor in the etiology of insanity, and there seems every reason to believe that brain surgery has an important future before it in the treatment of the epilepsy due to cranial injury. Echeverria reported 64 % of cures in 145 cases collected by him. But there are epileptics in whom upon trephining no spicula or rough edge of bone has been found, and yet the seizures have diminished or entirely disappeared, the mental condition showing a corresponding improvement. This beneficial effect of trephining where no local injury could be detected, has been regarded by some as due to counter-irritation simply, but may it not be ascribed to the relief of general intracranial pressure? Does not the relief of intracranial pressure open up a wide field for brain surgery? How often has one felt at post-mortem examinations on finding, for instance, large arachnoid hemorrhages, cysts, or greatly distended lateral ventricles, that, with the same knowledge a few hours before, one might, by trephining or tapping, have, at least for a time, averted a fatal issue? Then in some of the acuter forms of brain disease that end in death or in irretrievable injury to the brain, may we not look to the relief of intracranial pressure as at least a rational method of treatment, and one that should not be overlooked? He describes a case in his own experience of a man who had an abscess in the left frontal lobe, which perforated the temporal bone. As often as the pus accumulated and caused

intracranial pressure, epilepsy and maniacal excitement supervened. Then the abscess would discharge, the fits would cease, the mania disappear, and sanity be restored for a time. This coincident alternation of convulsions and mania, with perfect sanity after the discharge of pus, occurred several times. But, at the most favorable estimate, the surgical treatment of insanity will always be comparatively exceptional.

Although true that sedatives and hypnotics are powerless, as a rule, to cut short attacks of mania without doing more harm than good, should we not strive to find new remedies, even if our method be empirical; or despair of discovering something as efficacious in this disease as the salicylates are in rheumatism, or quinine in ague?

The mental treatment, a phrase the author prefers to "moral" treatment, is most important. It insists upon the immediate removal of the patient from the environment that has induced or aggravated his malady, and seeks to distract the mind from morbid ideas and emotions by occupying it with healthy employment or recreation.

The longer morbid mental action goes on, the greater will be the danger of the acquisition of a morbid habit. Insane ideas and actions by repetition tend to become habitual and automatic. The whole subject of habit in disease, and the unconscious memory at its base is very fascinating. An explanation of treatment by alteratives probably lies in their power to break up habit. May we not regard as constitutional alteratives those severe physical illnesses that frequently in the insane ameliorate the mental condition? How often patients become sane during the course of an acute malady, or immediately before death.

Although it is commonly held that argument with patients concerning their delusions is of no avail, and the delusions never yield to opposing facts, this has been demonstrated by Dr. Savage to be untrue in all cases, and this means of mental treatment certainly merits further trial.—*Brit. Med. Journal*, Sept. 1, 1888.

Finlay (David) on Epileptic Insanity.—The author has made a clinical study of 32 cases, 19 males and 13 females, at the Glamorgan Asylum in Wales. Insanity is the most dreaded complication of epilepsy, and a large proportion of epileptics, not congenitally imbecile, manifest sooner or later some impairment of the mind. It is stated by Dr. Reynolds that 50 per cent exhibit some mental disturbance. About 6 per cent. of the admissions into asylums have epilepsy as the cause of the insanity. It cannot positively be affirmed that the mental impairment bears any direct relation to the severity or frequency of the epileptic seizures. In the cases studied by the author from 2 to 34 years elapsed between the onset of the epilepsy and the first indications of mental disorder. The three most characteristic symptoms of epileptic insanity are irritability, impulsiveness, and defect of memory—illustrating grades in the direction of both mania and dementia. A special feature in the insanity of epileptics is the manifestation of strong religious tendencies. Dr. Maudsley has called special attention to this symptom, and in connection therewith refers to epileptic promulgators of certain creeds, such as Anne Lee, the founder of the Shakers; Swedenborg, and Mahomet.

Hallucinations of various kinds are extremely common in epileptics. Most of the females are obscene and erotic, and many possess delusions of a sexual nature. A considerable degree of morbid suspicion is common in epileptic insanity, sometimes amounting to delusions of persecution.

In 31 of his cases the urine was examined from day to day, irrespective of the occurrence of fits. No fewer than 21 had albumen in the urine. Sugar was not found in any. The average daily quantity of urine is small and the specific gravity low. Urea and phosphates are very deficient, and the phosphates are diminished at the expense of the alkaline salts. In some cases there is a relative increase of urea and phosphates, especially alkaline phosphates, on days when fits occur. The knee jerk was greatly exaggerated in 27 cases, and ankle clonus present at one time or another in 23.

DRUGS.	NO. OF CASES.	FITS ARRESTED.	FITS DIMINISHED.	NOT IMPROVED.	FITS INCREASED.	REMARKS.
Bromide . .	29	11	17	1	—	Acneform eruption in a few cases.
Antimony . .	19	—	2	11	6	Gastric disturbance in one case.
Antimony and aconite . .	8	—	3	4	1	
Arsenic . .	18	—	4	11	3	Physiological action in two cases.
Zinc	8	—	2	5	1	
Borax . . .	6	—	5	1	—	
Chloral . . .	6	—	—	5	1	Stupor induced in five cases.

As regards treatment, the foregoing table illustrates the influence of various drugs employed.

There could be no doubt that the bromides are the most efficacious, but the marked benefit from borax showed that the latter drug also deserves further trial.—*Glasgow Med. Jour.*, Sept., 1888.

Savage (Geo. H.) on the Mechanical Restraint of the Insane.—The author has used restraint considerably in the London Bethlehem Hospital for the insane, and was recently attacked in a lay paper by Dr. Bucknill for so doing. Hence in a letter to the *Lancet* Dr. Savage gives his reasons for its use. As this "fashion" of non-restraint is of English origin, and has been made an absolute law is some of our American asylums without regard to consequences, some quotations from a letter from one of the foremost English alienists will prove interesting to our readers:

In the Bethlehem Hospital the means of mechanical restraint in use were: (*a*) "Soft gloves," of which each hand is separate and padded to the thickness of about an inch, and which are fastened by a strap round the wrist with a screw button. (*b*) "Strong dresses," made of stout linen or woollen material, and lined throughout with flannel. The limbs are all free to move, but the hands are enclosed in the extremities of the dress, which are padded. (*c*) "Side-arm dresses" made of the same stuffs as the last, but in these there are two attached pockets to the side of the body of the dress, into which the hands of the patient are placed. By this means, though the patient can walk about his room, such dresses being used at night, he cannot make use of his hands to injure or destroy. (*d*) I employ the wet and also the dry pack. The former is so commonly used that I need not describe it; but as the dry pack is seldom used with the insane, I therefore wish to point out that in this mode of treatment I have the patient wrapped in a sheet or a blanket, and if very restless a second may be used. The patient is then placed on a mattress, and retained there either by means of an attendant or else by applying a sheet over patient, which is fastened under the bed. In a few instances, in which there was exhaustion, with some bodily ailment as well, such as swelling of the feet, I have placed the patient in a side-arm dress, and then lightly packed him, so as to ensure the recumbent position, and in one similar case I had tapes applied to the side-arm dress, and fixed to the bed. The result was the saving of the patient's life. I have used a belt once with attachment of the elbows to it, so that the patient, who was given to injuring himself by picking and rubbing, was thus prevented from so doing.

Next I shall give some of my reasons for the adoption of this increased amount of control. A patient who has "gloves" on can be allowed an amount of personal freedom which could not be granted otherwise. I allow patients who would undress themselves, who would attack others or injure themselves, all but uncontrolled liberty when they wear these soft gloves. I find the results highly satisfactory. Strong dresses, too, allow a large amount of liberty to more dangerous, and especially to destructive patients, without the irritation of the personal interference of attendants. The side-arm dresses have proved of the greatest benefit to patients who were constantly masturbating, or who were given to determined attempts at self-mutilation, to fits of impulsive violence, chiefly at night, or to wanton destructiveness. To sum up, I feel that if, on the one hand, I can grant more freedom by using one form of so-called restraint, while on the other I can induce rest and quiet, leading to recovery, by another method of control, I should be wanting in courage if I refrained from the use of these means simply because similar means in other times have been abused. At present it must suffice for me to say that I felt for a time restrained from doing what seemed likely to be useful to my patients because of this so-called principle of "non-restraint," but during the past two years I have gained confidence from experience, and I have tried the experiment with results which have justified my action, and, with Dr. Yellowlees of Glasgow, I would say that I acknowledge no principle of "non-restraint," but only the higher one of humanity and humane treatment, which, if it mean any thing, means the use of every method likely to restore health.—*Lancet*, Oct. 13, 1888.

Clouston (T. S.) on Secondary Dementia.—This was the subject of the author's presidential address delivered at the last annual meeting of the Medico-Psychological Association. The thoughtful summation of his ideas, some of which are quite novel and striking, is given below:

1. Normal brain cortex differs enormously in different individuals in its inherent qualities and potentialities, these differences being in the most important points necessarily "functional."

2. The strongest common clinical and psychological tendency of every form of mental disease is the tendency to end in dementia.

3. Dementia being a virtual death of the higher mental powers, all insanities, therefore, mean mind death and social death.

4. Dements constitute two thirds of our insane population.

5. Forty out of every hundred of all new cases of insanity soon pass into secondary dementia pure and simple, or mixed up with maniacal or delusional conditions.

6. The functional change that takes place in the brain cortex in secondary dementia is primary and chiefly confined to the mind tissue, and is, in fact, a unique disease in nature with no pathological analogies whatever.

7. The problem of what secondary dementia means and how it can be averted, is the cardinal problem of psychiatry.

8. Mental disease may be defined as "a tendency to dementia."

9. The constant association with dements alone tends to lower the mental tone of the staffs of asylums by the well-known law of the action of mind on mind.

10. Secondary dementia has as yet no sufficient pathological explanation.

11. It may be looked on as a reversion of type, as a failure of nature's power to complete her most organized and highest product, as a premature functional death of the mind tissue, or as a most beneficial result of the laws that bring a bad stock to an end.

12. Real secondary dementia may be so closely imitated by secondary stupor that only time and the effects of treatment can distinguish them. We may look on the primary maniacal attack as threatened dementia, and the secondary stupor as being a further stage towards it.

13. We have no reason to think that a brain which has a perfectly sound heredity can by any series of bad conditions known to us be made to exhibit typical secondary dementia.

14. The impressions through the senses from the outer world do not stimulate normally the cortex of a dement, though if the stimulant is very strong a certain response is obtained, but such a brain is incapable of providing such a stimulus by its own inherent working.

15. Dementia cannot be looked on as caused by the damage done to the mind tissue through the primary acute disturbance, for it often occurs without an acute primary stage, and its occurrence bears no definite relationship to the intensity of the duration of the primary attacks.

16. Most of the cases of chronic and delusional mania have also dementia superadded.

17. The pathological appearances, naked and microscopic, found in the brain cortex in long-continued cases of dementia are capable of explanation on the theory of the degeneration and atrophy of long-disused tissue; or they may be the advanced stage of the pathological condition, which is the real cause of the dementia, but which in its early stage we cannot as yet recognize.

18. No merely vascular theory of dementia is tenable.

19. Typical secondary dementia is always hereditary, and its genesis can be traced through the stages of hyper-activity, hyperæsthesia, diminished inhibition, instability, melancholia, mania, and alternation in different generations, or in members of the same generation affected in different degrees.

20. Pure and uncomplicated secondary dementia does not really supervene on the insanities that occur after full development and before the period of decadence, such as puerperal and lactational insanities, or those resulting from overwork or emotional causes at that age.

21. Melancholic and alternating insanities, delusional and inhibitory insanities, are not the preliminary stages of secondary dementia nearly so frequently as maniacal attacks.

22. Almost all pure cases of secondary dementia will be found to have originated in the developmental (pubescent and adolescent) insanities.

23. Masturbation may be an element in the production of secondary dementia in some cases, but it is not a necessary or a constant cause.

24. Idiocy and congenital imbecility represent nature's failures during brain growth, while secondary dementia is the typical failure during brain development.

25. Pure secondary dementia means that the organism has failed in its most highly organized structure and in its most important function just at the point before full reproductive perfection should have naturally been reached.

26. Undue and unphysiological means through a forcing-house mode of education during adolescence without regard to the hereditary capacity and weaknesses of the organism tend towards dementia.

27. The constant changes in each generation of modern civilized life in the adaptation of the human organism to its environments, and the special efforts thus rendered necessary by the struggle for existence, tend towards dementia through the strain they put on the most delicate of all organized tissues.

28. Adolescent insanity ending in secondary dementia may be regarded as the typical form of mental disease.

29. Dementia would have seemed a more natural sequence of the insanities of decadence (climacteric and senile) than of any others, for in them it would be a mere anticipation of the reproductive and mental death that has physiologically begun.

30. The lower animals, while subject to attacks analogous to melancholia and mania, are not subject to any state corresponding to secondary dementia before the senile period.

31. By prophylaxis in some cases, and by right treatment of the primary attack in others, dementia may be averted, but in many cases it is inevitable through the bad heredity of the individual.—*Med. Press and Circular*, Oct. 17 and 24, 1888.

Bell and Lemoine on the Opium Treatment of Anxious Melancholia. —The authors give a summary of their method of employing opium in this psychosis as follows :

1. As prolonged a stay in bed as possible. In this way cerebral anæmia is best resisted, and the patient removed from disturbing influences which often furnish material for delusions.

2. Every morning, on awaking, a glass of Hunyadi water. Constipation always yields to this medication.

3. Tincture of nux vomica, five drops daily in two doses, five minutes before the two principal meals.

4. Laudanum in progressive doses, beginning with five drops, in draughts, to be taken morning and evening. The dose is to be increased by five drops each day, until distinct amelioration in the patient's condition is evident. The writers had never had occasion to exceed in this way two hundred drops daily, but would not hesitate to increase the dose very much more if need be.

5. Spray baths of very short duration, and only when the physical condition has markedly improved. — *Annales Médico-Psychologiques*, March, 1888 ; *Boston Med. and Surg. Four.*, January 31, 1889.

[The Editor, who has employed the opium treatment extensively in melancholia, finds that this drug itself, contrary to the usual result, in some manner counteracts whatever cause there may be for the constipation which accompanies the disease. Therefore the Hunyadi water is not necessary, although doubtless an excellent adjuvant. Prolonged warm baths at night, from one half to two hours' duration, are the best promoters of sleep. There is no doubt that opium in the form of tincture or pill is better than any alkaloid, although the Editor has employed the bromide of morphia to a very great extent. There need be no danger of the subsequent formation of the opium habit, if the nature of the medicament be carefully concealed from the patient, a matter of no difficulty in an asylum, but requiring considerable circumspection at home. There is seldom any necessity for going above forty drops of laudanum three times daily, and cases are rare which require even that amount.]

Schüle on the Value and Advisability of Early Discharges from Asylums. — The author, at the annual meeting of the German Alienists at Berlin, September 17, 1888, expressed his views upon this subject. He thought every removal beneficial, first, when it is likely to hasten cure, and secondly, when stay in the asylum is actually injurious.

Melancholia is the condition most requiring asylum care. Homesickness, however, comes on in protracted melancholia and in convalescence. It often becomes a fixed idea. In these conditions, when it becomes imperative, early removal often has a good result. Otherwise the patient opposes treatment, falls off in flesh, sleeps poorly, and homesickness becomes almost a delusion. Carefully selected cases are greatly benefited by removal. In convalescence from the early stages, when the delusions are beginning to be corrected, there may be refusal of food. In this type

alone, early removal may be in such cases followed by the patient's beginning to eat. Other cases are those who are querulous, have morbidly increased anxiety about their health, and find new ailments each day. These, when tending to chronicity, may be harmed by longer stay in the asylum.

Mania.— Mendel's hypomania (mania mitis) and reasoning types are often irritated by asylum discipline; also those protracted cases of mania who are convalescing, and are independent, regardless as to their conduct, and impulsive. Patients of this class behave badly because they are "in an asylum," and feel that they may do as they like. The pressure of outside life steadies them.

Paranoia, with delusions of persecutions.—In the early stages some cases reach a point where the asylum experience is woven into the delusion, and discipline adds to the morbid ideas. If removed for a time such patients instinctively do well until they become used to the new conditions. Some actively oppose discipline, others passively resist it. They may go on to dementia, while change, new surroundings, etc., may serve to resist this tendency. Great irritability contra-indicates removal.

Acute paranoia,convalescing stage.—Consciousness once more becomes cognizant of surroundings. The healthy and morbid elements of consciousness, however, are mixed. Here early removal is the best and quickest means of remedy, provided there exist a healthy nucleus of consciousness and intelligence.

Chronic secondary conditions.—There are *many* of this class for whom asylum life is not the right medium, and does harm. Such do better outside.—*Boston Med. and Surg. Jour.*, January 31, 1889.

Mental Depression and Uric Acid.—A. Haig, in the *Practitioner* of Nov., 1888, considers the relation of mental depression to the excretion of uric acid. A certain form of headache bears a close relation to such excretion; and the author's researches concerning headache have shown him that mental depression and its opposite condition of well-being and exaltation are also dependent upon the amount of uric acid in the blood. Variation of this amount may produce or put an end to headache; and, in like manner, mental depression or the joy of living may be called into existence. The amount necessary to produce headache is probably greater than that required for depression or irritability. It has been noticed that a number of persons suffer from a certain amount of mental depression and heaviness at the time of day when the excretion of uric acid is at its greatest—that is, in the morning between breakfast and luncheon,—when the acidity of the urine is lowest. This Sir W. Roberts calls the "alkaline tide." The process may be reversed at any time; and by giving acids sufficient to overcome the alkaline tide, heaviness and low spirits may be made to give way to a feeling of well-being. One or two 15-drop doses of a mineral acid may produce this effect. The washing out of uric-acid accumulations may be accomplished by the use of salicylate of sodium (15 grains three or four times daily). The question of diet is considered at length.—Extracts from editorial in *N. Y. Med. Jour.*, March 23, 1889.

MISCELLANY.

Townsend (C. W.) and Coolidge (A.) on the Mortality of Acute Lobar Pneumonia.— The authors summarize their studies as follows:

1. In the 1,000 cases of acute lobar pneumonia treated at the Massachusetts General Hospital from 1822 to 1889, there was a mortality of 25 per cent.

2. The mortality has gradually increased from 10 per cent. in the first decade to 28 per cent. in the present decade.

3. This increase is deceptive for the following reasons, all of which were shown to be a cause of a large mortality:

(*a*) The average age of the patients has been increasing from the first to the last decade.

(*b*) The relative number of complicated and delicate cases has increased.

(*c*) The relative number of intemperate cases has increased.

(*a*) The relative number of foreigners has increased.

4. These causes are sufficient to explain the entire rise in the mortality.

5. Treatment, which was heroic before 1850, transitional between 1850 and 1860, and expectant and sustaining since 1860, has not, therefore, influenced the mortality rate.

6. Treatment has not influenced the duration of the disease or of its convalescence.—*Med. News*, July 27, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLE.

NEPHRECTOMY.

In an editorial in the *Medical and Surgical Reporter* for June, 1888, it is said that "an operation which has now been performed more than four hundred times cannot be said to be any longer on trial; and it seems to be clear that the successful performance of it may be regarded as a question of skill in diagnosis and dexterity in practice."

Nephrectomy on the living subject was first performed as a premeditated operation by Gustav Simon, of Heidelberg, in April, 1869. Three different surgeons had preceded Simon in excising the human kidney, but without knowing the nature of the tumor they were removing until the operation had been completed. The first of these operations was performed in 1861, the others in 1867 and 1868. The ventral method was employed in each, and they all died. In Simon's case the lumbar method was adopted. The patient recovered. The different operations for the removal of the kidney are lumbar nephrectomy and removal by abdominal section. The section can be made either through the linea alba or through the semilunar line. For the removal of new growths of the kidney, the lumbar operation would be resorted to only when the tumor is small. By abdominal section we have better access to the organ, and are there better able to deal with adhesions and with the pedicle; at the same time the opposite kidney can be examined. In favor of the lumbar operation is the fact that we do not wound the peritoneum, and that we are supposed to have better drainage, but by using the glass drainage-tubes with the cotton rope, the drainage after abdominal section is quite as satisfactory as after that of the lumbar region (Deaver, *Med. and Surg. Reporter*, June 16, 1888).

The conclusion at which Dr. Deaver arrives, in regard to the indications for nephrectomy are these: First, sarcoma of the kidney in children contra-indicates operation; second, sarcoma of the kidney in the adult is a justifiable cause for operation; third, carcinoma of the kidney in the adult, unless coming under the surgeon's notice very early, contra-indicates operation; fourth, malignant growths of the kidney in the majority of cases should be removed by abdominal section, after the manner of Langenbuch; fifth, benign growths of the kidney are cases for the lumbar operation, but when too large to be removed *en masse*, should be removed in sections, the precaution being taken to ligature the pedicle before cutting away a section of the tumor.

It is probable, states Morris, that renal sarcoma in children, as also cancer at any period of life, will by future experience be excluded from the category of "cases for nephrectomy" performed by any method. In cancerous tumors it is not likely that life can be greatly prolonged, unless in the exceptional cases in which the disease is detected before it has long existed, or has affected the lymphatic system.

At a meeting of the New York Surgical Society, December 12, 1888 (*N. Y. Med.*

Jour. Feb. 16, 1889), Dr. Lange showed a patient, and related the following history: The man, whose father died of locomotor ataxia, and his mother of phthisis, was never ill until eight years ago, when he began to suffer from attacks of frequent micturition and vesical tenesmus. In the fall of 1886 he had a sudden chill, accompanied by pains in the loins and bladder. After passing some blood he felt relieved. He was first seen by Dr. Lange in the middle of February, 1888, in consultation with Dr. Stimson and Dr. Loomis. The patient was confined to his bed, and was in very poor general condition, so that it was decided to drain the kidney through lumbar incision. On exposing the organ, however, it was found to be so diseased that it was decided to remove it. Krenig's oblique incision along the crest of the ilium was added to the ordinary lumbar one, which greatly facilitated the removal of the kidney. A temporary elastic ligature was placed around the pedicle. The latter probably became vascularized, as it was seen at the bottom of the wound some time after the operation covered with small reddish points of granulation, and it was never expelled. The ligature had to be removed at the end of four weeks, and a fistula remained, which eventually healed. The patient had a slow convalescence, being in a state of acute mania for two weeks, so that he required two attendants. He was now in good health, his urine being quite normal. In reply to a question by Dr. Weir, the speaker replied that the patient's mania could not have been due to iodoform poisoning, as that drug had not been used in powder; the wound was packed lightly with weak iodoform gauze for the first twenty-four hours. There was very little elevation of temperature during the delirium, although the pulse was greatly accelerated.

Dr. Lange also showed a specimen of cystic pyonephritic kidney of unusually large size. It developed in the left side, and reached the size of a man's head. The patient had had no pain, but only gradual loss of strength, and detected his tumor accidentally. The relations of the colon to the tumor had been satisfactorily established by inflating the gut by the aid of a stomach-pump introduced into the rectum. The incision was very long—longitudinal lumbar with two cross incisions along the border of the ribs, and the crest of the ilium—and it was necessary to resect a portion of the eleventh rib. There were several separate cysts, containing a thick viscid, purulent fluid, which were emptied in turn. The operation lasted between two and three hours, and the patient had made a good recovery. Dr. Lange said that he always performed retro-peritoneal nephrectomy when he found infection. In the case of large tumors it might be necessary to open the peritoneal cavity. Dr. Weir asked him why he had departed from the usual custom of performing nephrotomy as a preliminary step to nephrectomy. Dr. Lange replied that in a number of cases he had attempted to preserve a diseased pyonephritic kidney by limiting the operation to nephrotomy, but patients generally lost more than they gained, owing to the prolonged suppuration. The only advantage was that it was easier to do nephrectomy subsequently. In only one instance did he succeed in saving a kidney by draining it. It depended upon the degree of disorganization whether the kidney ought to be removed or not. Dr. Weir said that experience had taught surgeons that in the case of patients who were in bad condition nephrotomy offered a better chance of recovery than primary nephrectomy. In some cases, however, the abscesses were separated from one another, or did not communicate with the general cavity of the pelvis of the kidney. In such, immediate nephrectomy was preferable. (*N. Y. Med. Jour.*, Feb. 16, 1889.)

Dr. Weir reports a case of a child of eleven (*N. Y. Med. Jour.*, March 30th), from whom both a lacerated spleen and a kidney, whose efferent veins were torn across, were removed twenty hours after the child had fallen a distance of twenty feet. The child lived only nine hours after the operation.

M. Tillaux of Paris (*Med. Press*, March 27, 1889) removed the right kidney from a man whose ureter had been ruptured by the kick of a horse. There was also rupture of the cæcum in this case. The patient made a good recovery.

Dr. M. Price (*Med. News*, Jan. 21, 1889) reports the case of a young girl in which a bullet pierced the liver and the right kidney, and buried itself in the spinal muscles. At the time of the operation, twenty-four hours after the accident, the pulse was 150, the temperature 103°, peritonitis had set in, and the patient was in

collapse. An incision six inches long was made, arterial blood was seen to be escaping from the right kidney. The kidney was removed. The liver wounds were dry. Rapid improvement continued for nine days, but there has since been a rise of temperature, and on the nineteenth day the temperature is 100°, the pulse 108, and the patient is doing well.

Dr. W. O. Roberts (*Med. Record*, July 28, 1889) reports a case of recovery after nephrectomy for sarcoma in a child of 5½ years. GERTRUDE B. KELLY, M.D.

OCCASIONAL REPORT ON DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

Shoemaker (Geo. E.) on the Early Recognition and Treatment of Malignment Disease of the Uterus.—After a detailed account of the varieties, symptoms, signs, and treatment of malignant disease of the uterus, the author sums up as follows, after expressing an opinion in favor of partial excision of the organ, as opposed to extirpation, both in the matter of immediate and of remote results:

a. Early diagnosis is all-important, and should not be deferred until gross changes have occurred.

b. Examination should follow slight suspicions from the treacherous character of the symptoms. If not conclusive, it should be made by a trained hand.

c. The microscope will sometimes detect before other means will.

d. Heredity is a doubtful cause, traumatic origin very probable.

e. Lacerations of the cervix, where the growths usually begin, should be repaired if causing irritation, and erosions should be cured. If erosions are stubborn, or otherwise suspicious, they should be pared off.

f. In epithelioma especially, the disease is at first local, and if taken early complete immunity is secured sometimes, and always great saving of time and suffering.

g. From an operative point of view, there are three periods in any form of malignant disease:

1. Early, when operation should be immediate and as radical as possible, without extirpation of the uterus.

2. Intermediate, when, eradication being impossible, nothing should be done unless demanded by severe hemorrhage or extreme pain. The length of this period is indefinite, and depends on the rapidity of growth.

3. Late, when scraping and burning may be done repeatedly, to palliate symptoms and retard growth.—*Polyclinic*, May, 1889.

Croom (J. Halliday) on Hemorrhagic Endometritis Simulating Intra-Uterine Cancer.—Two cases in the author's practice are cited, in which periodical pains, irregular hemorrhages, leucorrhœa, and excessive tenderness when the sound was passed to the fundus uteri were the prominent symptoms of the patients, who were aged 60 and 56 respectively, and long past the menopause. The diagnosis was made by the microscopic examination of tissue removed by curetting. Relief followed the operation in both cases, one having no return, but dying after 2 years of another disease, and the other requiring another operation after three months. The tissue removed showed a predominance of glandular elements, but no distinct signs of malignant character.—*Med. Press*, May 22, 1889.

Vaginal Hysterectomy for Cancer.—A report of 27 operations without a death in the practice of Dr. Rubeska, of Prag, those having been performed within a period of four years, does much toward improving the status of the operation. One of these cases was not complete, the parametrium being extensively involved. The after history shows that of the 17 cases which remained under observation up to July 1, 1888, ten remained well after periods of 46, 23, 23, 18, 13, 12, 11, 14, and 3 months respectively. Three died with recurrent cancer; two presented a recurrence on that date; and two had died from other diseases without any recurrence of the growth whatever.—Transl. in *Jour. Med. Assoc.*, June 8, 1889.

Janvrin (J. E.) on an Unusual Cause of Death after Abdominal Section.—The history of a case in which a myxo-sarcoma of the tube had been removed by abdominal section is related by the author, in which violent pain in the epigastrium came on soon after the operation. Morphine, atropine, and other anodynes were administered without effect. Fæcal vomiting ensued, and the abdomen was reopened. No signs of peritonitis or obstruction of the gut could be found. He

believed the cause of the pain and vomiting to be a nervous exhaustion of the whole alimentary tract, due to the previous long-continued use of morphine. He had in former years had exactly similar cases, characterized by stercoraceous vomiting, in which no peritonitis or interstitial obstruction could be demonstrated at the autopsy.—*N. Y. Med. Jour.*, June 1, 1889.

Foster (Frank P.) on the Periodicity and Duration of the Menstrual Flow.—From the study of the menstrual function as occurring in 56 women who were under treatment for some form of pelvic disorder, but who did not consider themselves as afflicted by any menstrual abnormity, no less than five periods in any one case were observed, the largest number being eighteen. Only one case of perfect periodicity was observed, the interval being 26 days. In the others the intervals varied from 16 to 29 days to from 34 to 36 days. Out of 380 menstruations, 45 had occurred after 28 days, 225 after shorter intervals (16 days being the shortest), and 110 after longer intervals (the longest being 46 days).

As to the duration of the flow, it had ranged from 1 to 14 days. In two cases only had the duration of the flow been the same at all periods. These data had been furnished by the patients themselves, and were hence not perfectly reliable. The author infers from these statistics that many women are very irregular without knowing the fact, and consequently the statements of patients as to this fact should not be recorded in the history of the case on the statement of the patient alone.—*N. Y. Med. Jour.*, June 1, 1889.

Marcy (H. E.) on Reduction of an Inverted Uterus by a New Method.—The author's method is based on the principle of applying traction to the cervix simultaneously with pressure on the inverted fundus. This is accomplished by the use of an instrument consisting of a shaft with a cup-shaped extremity for the reception of the fundus, contained within a movable sleeve, which is provided with four small rings. Four strong silk ligatures are passed deeply through the cervical tissues and fastened to the rings on the instrument. Then, by means of a screw in its handle, pressure is brought to bear on a concealed spring (the force exerted by which being indicated upon a graduated scale), by the action of which the fundus is pressed upwards, the sutures serving as a means of counter pressure, as well as assisting to dilate the cervical ring as the fundus is forced through it. Although the method was devised some twelve years since, it had never been put in practice until recently, when an inversion of three months' standing, in which prolonged taxis had failed, was induced by the new method in 26 minutes, with a pressure of 8 pounds.—*Jour. Am. Med. Assoc.*, July 20, 1889.

Potter (W. W.) on the Gynecic Uses of Boric Acid.—The author's experience with this agent has led him to the following conclusions:

1. That boric acid is suited to many gynecic uses where antiseptics are required.

2. That it can claim superiority for vaginal tamponnement by reason of (*a*) odorless, (*b*) colorless, (*c*) non-irritant, chemical properties; these admitting of its frequent, liberal, and prolonged employment where this method of treatment is indicated.

3. That it is a remedy of value in sterility due to acrid secretions that destroy the fecundating power of the spermatozoa.

4. That it is one of the best powders to render operation wounds in the genital tract aseptic.—*Jour. Am. Med. Assoc.*, July 13, 1888.

Cullingworth (C. J.) on the Etiological Importance of Gonorrhœa in Relation to Some of the Common Diseases of Women.—Acute gonorrhœa in the female is not, as is usually stated, an acute vaginitis in the greater number of cases. When vaginitis is present, it is usually slight in degree and of insignificant importance. The more constant lesions are inflammation of the ducts of the vulvo-vaginal glands, and the mucous membrane adjacent to their orifices, urethritis and inflammation of the cervical mucous membrane, accompanied with erosion about the os uteri, and a purulent discharge. The inflammation tends to spread to the endometrium and the mucous membrane of the tubes.

While not admitting the extreme dicta as to the incurability and latency of gonorrhœa in the male, the author believes that the disease, although apparently cured, may be roused into activity by sexual intercourse and infect the woman, as has apparently been the case with the newly married, and can be assigned as the cause

of the broken health of girls who had been perfectly healthy before marriage.

Several histories of cases of pelvic inflammation are reported, a distinct history of gonorrhœal infection being present in all. In one case, in which a hydrosalpinx was removed by laparotomy and resulting fatally, the autopsy revealed ulceration of the tube at the outer part of its uterine portion, septic peritonitis being caused as a result of perforation of the wall of the tube at this point. The author believes gonorrhœal infection to be second only to post-partum sepsis as a cause of pelvic inflammation, and urges the necessity for active treatment in all cases showing the symptoms of gonorrhœa. Believing the gonococcus to be the cause, he applies strong carbolic acid to all inflamed or eroded surfaces, or, when this cannot be used, a 1 to 1000 solution of bichloride of mercury. —*Brit. Med. Jour.*, July 20, 1889.

Johnson (Jos. Tabor) on Tetanus Following Ovariotomy.—A amall ovarian cyst was removed from a patient æt. sixty, a drainage-tube being used. No trouble ensued until the twelfth day, when symptoms of tetanus appeared, increasing in severity until the death of the patient on the fifteenth day. No cause, sanitary or other, could be found. The operator had not been near his horses, which were healthy, for several days. Only a few similar cases are on record, and the complication has usually occurred within a very few days after the operation.—*Obstet. Gazette*, July, 1889.

Stimson (L. A.) on a Modification of Technique of Abdominal Surgery.—The author, in order to avoid the danger of secondary hemorrhage and the necessity of leaving a raw surface uncovered by peritoneum, as well as the strain upon that membrane caused by ligating a pedicle *en masse*, recommends the following management of the broad ligaments in abdominal hysterectomy or removal of the adnexa of the uterus: A long-bladed clamp is fastened nearly transversely on the ligament well below the ovary, and the portion above the clamp cut away. The exposed vessels are then ligated without disturbing the peritoneum, the clamp is removed, and the cut edges of the ligament retract to their normal position in the pelvis. The gap is then closed by a continuous catgut suture over the ligated vessels, and all danger of slipping of the ligature, or oozing from an exposed new surface is obviated. When hysterectomy, complete or supra-vaginal, is performed, the author first locates the uterine artery—is found by palpation, at the lower part of the broad ligament, preferably on its posterior surface, is exposed by an incision through the peritoneum, and ligated with catgut. The broad ligaments are then treated as just described, and the body of the uterus is then removed. If the cervix is to be left, the peritoneum is so divided as to form two flaps, which are sutured over the cut surface of the stump, a drainage-tube being passed through the canal of the cervix into the vagina to drain the subperitoneal space. If the cervix is to be removed, it is carefully separated from the bladder and posterior attachments, and removed by incision of the vaginal walls. The peritoneal flaps, anterior and posterior, are then turned downward into the vaginal wound until their serous surfaces are in contact, and a drainage-tube can be passed into the vagina posteriorly if desired. Preliminary ligation of the uterine arteries effectually prevents all hemorrhage, except that from small vessels in the cut edge of the vagina. The author maintains that all vessels of any importance should be separately ligated *subperitoneally* in the abdominal cavity, and that the ligation *en masse* should be avoided as much as possible, as it is only reliable when applied to thin, narrow pedicles. The uterine artery must be ligated low down in the pelvis, and at a point in its course proximal to the origins of its large branches, or troublesome hemorrhage may occur and time be lost in securing the bleeding vessels. The great advantage of the method as applied to supra-vaginal hysterectomy is the security afforded for the intraperitoneal treatment of the pedicle.—*Med. News*, July 27, 1889.

Williams (C. P.) on a Case of Tubal Pregnancy Terminating in Natural Delivery.—Patient had last menstruated in October, 1888, and up to date of consultation (Jan. 29, 1889), had only noticed a reddish leucorrhœal discharge, but had had no nausea. She was in good condition, all functions being normal, and examination only showed fulness of mammæ, increased size of the abdomen, and tenderness over the pubic region; vagina of normal color, and cervix somewhat soft, with patulous os, from which a

free mucous discharge was emitted. She believed herself pregnant, despite the expressed opinion of the author to the contrary. During the following month the reddish discharge was continuous and more copious, and the patient complained of severe pains, referred to the region of the bladder. At the end of February, 1889, a tumor was discovered in the pubic region, extending toward the left side, examination of which revealed the outlines of a fœtus. Ballottement was obtained by bimanual examination, and the uterine cavity was explored by the finger and found to be empty. The diagnosis was then made—extra-uterine pregnancy, but the expectant plan of treatment was followed. During March the bloody discharge continued, and the pains increased in severity, demanding large doses of opium for the relief of the patient. The author had requested a surgeon to hold himself in readiness for operation, but on April 1st he was called to see his patient, found her in intense agony, and on passing his finger into the uterine cavity was astonished to find it occupied by the fœtus, which was expelled *per vaginam* three hours later. The fœtus was of about four months' development, and was living when born. About one month later the patient was entirely well, and only a small tumor of the size of an English walnut, situated at the left of the uterus, and midway between the pubes and umbilicus, was found in place of the gestation sac.—*Med. News*, July 27, 1889.

Stephenson (W.) on the Relation between Chlorosis and Menstruation.—Basing his remarks on an analysis of 232 cases, the author advanced the following opinions: Dividing the cases into two groups—primary, in which the attacks occurred before the twenty-third year, 183 in number, and those cases in which the disease occurred as a relapse after a period of good health, 49 in number—he showed that, although chlorosis is due to a constitutional state, it is by no means necessarily associated with poor bodily development, or with defective health previous to its appearance. By tables it was shown that the chlorotic diathesis tended to accelerate the age at which the catamenia appear, and is not, in itself, a cause of the retardation of menstruation. But in one half of the cases functional activity was defective, and characterized by irregularity and lengthening of the intermenstrual periods and scantiness of the amount of the flow. Two marked chlorotic periods were demonstrated by the tables—the primary, occurring between the ages of fourteen and twenty-one, and that of secondary attacks between the ages of twenty-four and thirty-one. Two cases were recorded in which the attack occurred at the ages of thirty-nine and forty-one. The general conclusion reached was that imperfect evolution of menstruation, as evidenced by the scantiness of the flow and the irregularity of the periods, was as regular a feature of chlorosis as was the imperfect evolution of the red corpuscles of the blood. These constants are independent of each other, but so related that the reproduction or formation of the erythrocytes forms part of, or is governed by, the menstrual cycle, both being influenced by a greater rhythmic action which determines the time and activity of development, growth, and reproduction. The author was sceptical as to the existence of the so-called menorrhagia of chlorosis.—*Obstet. Gazette*, July, 1889.

Wathen (W. H.) on the Pathology of Ectopic Pregnancy and Pelvic Hæmatocele.—The author advances the following premises:

1. The ovum is never fertilized in the uterine cavity, but only just before or after it has entered the tube.

2. With the possible exception of the ovarian variety, ectopic gestation is always primarily tubal, the sac usually rupturing before the fourteenth week.

3. Abdominal pregnancy within the peritoneal cavity never can occur, except as a result of rupture of the sac, and can only continue its progress when the villous or placental attachments are retained.

4. Interstitial pregnancy usually ruptures into the peritoneal cavity, but not always.

5. If pelvic hæmatocele be defined as an encysted or confined tumor formed of blood, the intra-peritoneal hæmatocele is not possible.

The unimpregnated ovum loses its vitality before reaching the uterine cavity; and if impregnated it cannot form villous attachments until it is held immovably in the maternal structures, this being impossible, except in the uterus or the tube.

The reports of cases of ovarian pregnancy are based on insufficient evidence, those in which ovarian tissue has been found in the sac-wall probably having been originally tubal in variety, the sac having

ruptured between the folds of the broad ligament, and having subsequently become attached to the ovary. Intra-peritoneal pregnancy is never primary, as the ovum cannot be held securely, and therefore form the necessary attachments. Abdominal pregnancy is either secondary to rupture of a tubal gestation sac directly into the peritoneal cavity, or between the folds of the broad ligament, where the pregnancy may continue extraperitoneally, or another rupture may occur, the fœtus escaping into the cavity of the peritoneum, where it may continue its development. The placenta may be attached to the uterus, omentum, intestine, abdominal wall, etc. In late abdominal pregnancy the fœtus may continue to live after rupture of the amnion.

Intra-peritoneal hæmatocele is never encapsulated, cannot be recognized as a well-defined tumor by physical examination, and is usually dependent on rupture of an ectopic gestation sac. This is accompanied by symptoms of shock and of internal hemorrhage.

Extra-peritoneal hæmatocele—the encysted form—is caused by sudden metrostaxis of normal menstruation, pseudo-menstruation following abdominal or pelvic operations, or rupture of a tubal gestation sac between the folds of the broad ligament. The blood is forced into the areolar tissue underlying the peritonem, forming a more or less defined tumor, and often associated with symptoms of shock.

In the first form ligation of the bleeding vessels by laparotomy is indicated. In the latter the blood is usually absorbed, though suppuration or escape into the peritoneal cavity may occur. In case symptoms of either accident appear the abdomen should be opened, the cavity cleansed, and a drainage-tube introduced.—*Obstet. Gazette*, July, 1889.

Jaggard (W. W.) on the Treatment of Puerperal Eclampsia.—In closing the discussion on a paper on this subject, the author thus sums up his own ideas as to the treatment of eclampsia :

1. When occurring early in pregnancy, the question of inducing abortion should be seriously considered. Hot-water baths are most effective in the prevention of, and least in the cure of, eclampsia.

2. Later in pregnancy, an expectant plan should be followed, unless labor or abortion is imminent. In such case, hasten the evacuation of the uterus. Otherwise, wait until after convalescence is well established before interrupting the pregnancy.

3. In eclampsia occurring during labor, the indications are : (*a*) Protection of the patient from injury during the convulsions ; (*b*) controlling the convulsions by *profound narcosis*, which may be produced by inhalations of chloroform and by rectal administration of large doses of chloral and the bromides ; the narcosis should be *deep and continued* ; (*c*) evacuation of the uterine contents as rapidly as consistent with the condition of the mother and child. Early in labor, before dilatation of the cervical canal, puncture of the membranes is usually the best means or accelerating the labor. After dilatation has commenced, and the cervix is obliterated, digital dilatation is indicated, delivery being accomplished by the use of the forceps or by version, according to the conditions present.

4. Elimination of the excrementitious matter from the system by producing purgation, diaphoresis, and diuresis. The hot pack is probably the best means, and vapor baths are efficient and easily administered. Pilocarpine should be used with the utmost caution only at the beginning of the attack, and when the coma is light, the pulse full, and the respiration free.

The author strongly opposes venesection as unphilosophical and ineffective, citing the opinions and statistics of a number of German obstetricians as opposed to the practice of bleeding in eclampsia, and as showing a lessened percentage of mortality since they had abandoned its use. The use of veratrum viride is preferable.

5. The greatest care in avoiding any septic infection must be exercised.

[Almost all of the gentlemen who took part in this discussion were more or less strongly in favor of venesection as a means of treatment of eclampsia occurring in plethoric or well-nourished women. J. S. H.] —*Obst. Gazette*, July, 1889.

MISCELLANY.

Gärtner[1] on Meat Poisoning.—On the 11th of May, 1888, in Frankenhausen, W——, a laborer twenty-one years of age, was taken ill two hours after eating

[1] *Breslauer aerztlich. Zeitschrift*, 1888, Nos. 21–24. Translated and Abstracted by Walter Vought, M.D.

800 grammes of raw beef. The symptoms presented were severe vomiting and diarrhœa. On the 13th of May the patient died. The autopsy showed an inflammation of the small intestines, the solitary follicles and Peyer's patches being swollen, and in the mucous membrane of the stomach smaller and moderate-sized hemorrhages were found.

In the time intervening between the 11th and the 18th of May 58 persons were taken sick in the same town with the symptoms of a severe gastro-enteritis.

In all cases there was much general disturbance; fever being present, rising above 40° C. The duration varied according to the severity of the cases from a few days to four weeks, and during convalescence desquamation took place, the skin on the palms of the hands and soles of the feet being likewise affected. Of those taken sick, 25 were children under fourteen years of age; the ages of the remainder being from eighteen to sixty-six years. It was proven (the mother of the above-mentioned laborer only denying it, she falling ill on the 14th of May) that all of the 58 affected had partaken of meat from the same animal as W——, and that 12 of these had eaten raw meat; the remainder either boiled meat, broiled liver, or soup.

In addition to the 58 affected, 36 persons had eaten boiled meat from the same animal, and they all remained healthy.

Of the remaining inhabitants of the village, none of whom had eaten any of the meat, none presented similar symptoms. The surest symptoms were presented by those who had eaten the raw meat, and were proportionate to the amount eaten. On the 13th of May the diagnosis of meat poisoning was made, and meat from the carcass was immediately sent to the hygienic institute at Jena for examination, and later on the spleen, liver, and the kidneys of the man W——, together with the intestines of the animal.

The affected animal came from a farm in the neighborhood of Frankenhausen, where the health of the large herd of cattle was, on the whole, good. The animal was taken sick in May with diarrhœa, was treated with opium, etc., and had to be killed on the 9th of May.

Examination showed only the signs of an inflammation of the small intestines, and the meat, which seemed normal, was declared by the veterinary as fit for food.

Bacteriological examination of tube of cultures made from the beef, as well as from the spleen of W——, showed that only one kind of bacilli could be grown, which were also only obtained from plate cultures made from the same material.

The cultures of the bacilli in nutrient gelatine were light-gray, transparent, and coarsely granular in appearance. The single bacilli were short, thick rods, and mostly surrounded by a zone, easily stained, but the coloring matter was on the middle, the ends remaining free. On blood serum and agar-agar they grew quickly, but were smaller, and did not show the above-mentioned peculiarity in staining. Variations were often present, but their identity was always proven by cultivation. Microscopical sections of the meat, hardened in alcohol, gave the same bacillus in masses, filling the lumen of the blood-vessels. In all portions of the meat and organs examined, there was only found this bacillus, to which Gärtner gives the name of bacillus enteridis, and in beef from other cattle, and in the human corpse, and even in decomposed meat, the same bacillus was not found.

Numerous and various inoculative experiments gave the following results: Dogs, cats, and chickens could eat the meat containing the bacilli without harm; mice were killed both by the meat and cultures; subcutaneous or even intravenous injections of the bacillus enteridis were fatal in most cases to rabbits and guinea-pigs, and in the dead animals the bacillus enteridis was found.

If the infected meat or the gelatine cultures were boiled, and the bacillus thereby destroyed, it was possible to produce a fatal effect in many animals, but this only occurred from the administration of large amounts of the material, death therefore taking place from an intoxication. The animals dying after infection showed especially the appearances of an enteritis; those after intoxication presented the symptoms of paralysis of the nervous system, and in these, inflammatory changes in the intestine were seen. This is the first time that a characteristic bacillus has been proved with certainty to be the active agent in a poisoning by meat.—*Centralblatt für klinische Med.*, 1889, No. 24.

Newman on the Changes that Take Place in the Mucous Membrane of the Vagina.—The author reviews the

clinical appearance of the vaginal tract after long cohabitation, pregnancy, senile atrophy of the membrane, and finally dwells at some length on the simple vaginitis or kolpitis, or colpitis. He defines two well-marked forms of colpitis. The first comprehends vesiculosa, exfoliative (dysmenorrhagic), and the miliary varieties. The second form includes granulosa, papulosa, and follicularis colpitis. The histological appearances of the different varieties agree closely with that given by Ruge. The atrophic changes in senile vaginitis are characterized by the fibrous part of the reticulated tissue becoming enlarged and reducing the network of the cellular tissue, while the epithelial layer becomes absorbed, allowing the elastic tissue to come more to the surface. In the pregnant condition the epithelial tissue forms itself into plates or balls filling up the folds of the mucous membrane. To the question, whether pure and simple inflammatory colpitis could take place, he is prepared to answer in the affirmative. We have redness, swelling, and enlargement of the vessels as in other inflammatory conditions elsewhere. It is possible for the membranes of the vagina, by their rapid formation of flat epithelial tissue, to stand any reasonable irritation, but it must be remembered that repeated cohabitation, long retention of any infectious material, maceration, desquamation of the epithelium, paralyzes this generative power of the membranes and exposes the organ to all the dangers of inflammation.—*Med. Press*, July 17, 1889.

Stephenson (W.) on the Influence of Permanganate of Potassium on Menstruation.—The study of my cases, from a constitutional point of view, apart from its action on menstruation, tends to indicate that manganese acts on the vaso-motor system, improving and giving tone to the circulation. This is well seen in a constitutional state met with in young girls. They are not anæmic, rather the reverse, full-blooded with languid circulation; the chief characteristic is that the face and extremities are hoven, with a tendency to blueness; there is a great loss of energy and a disposition to drowsiness in the daytime. Under the permanganate this constitutional state steadily improves. At first there may be a loss of weight, the color becomes clearer, the fulness of the tissues subsides, and the energy returns. The loss of weight I have several times observed in patients taking the permanganate is not due, in my opinion, to increased combustion of the tissues, but to the diminution of the watery elements of the blood and tissues. The condition is not œdema, but a vascular fulness.

Much of the relief to menstrual suffering afforded by the permanganate is doubtless due to the improvement in vascular action. Several of the cases, which time will not permit to quote, clearly indicate that some forms of menstrual pain are caused by vascular distention and increased venous blood-pressure. It is in these cases the remedy may be relied upon to afford relief, and so improve the system that the suffering does not return at subsequent periods. The influence of the remedy on leucorrhœa is likewise, in all probability, due to the improvement in the circulation. The effect in affording relief to the ovarian pain admits of the same explanation.

The vascular changes associated with menstruation are, however, not merely local, but truly systemic. The relief obtained in headaches can therefore be also understood by an improvement in the general circulation. But, as we have seen, the remedy influences not only the amount of the discharge, but also the time, by restoring the normal periodicity. This points to an influence on the nervous system. Laschkewitsch has shown that in toxic doses "manganese causes general paralysis, at the same time the heart's action ceases, owing to the direct effect of the drug on the motor apparatus." From these pharmacological experiments, together with the results of clinical observation, we may confidently infer that the direct action of the remedy is on the vaso-motor centres, and from the marked influence on menstruation it is probable that it stimulates especially the centres regulating the generative system.—*Br. Med. Jour.*, July 20, 1889.

Christian (E. A.) on the Relation of Chronic Bright's Disease to Insanity.—A plausible and brief summary of this author's views upon an uncertain subject is as follows:

1. The frequency with which evidences of chronic Bright's disease are found associated with mental derangement leads to the belief that the latter condition is often dependent upon the former as its cause.

2. This belief finds support and explanation in the present accepted ideas of the

pathology of chronic Bright's disease, according to which the disease is no longer regarded as confined to the kidneys, but as possessing features which make it essentially vascular. These consist in structural alterations in the blood-vessels of the brain and spinal cord, as well as in the vessels of other organs of the body.

3. There are cases of insanity with chronic Bright's disease which are of uro-toxic origin, but in the majority of cases the mental manifestations must be regarded either as an expression of lowered nutrition or, as is more frequently the case, due to vascular changes in the brain, attended often by convulsions of other than uræmic origin; disturbances of speech and of locomotion.

4. Finally, in many cases of dementia with paralysis it will be found that the destructive brain lesion, with subsequent decay of the mental faculties, is the result of an alteration in the vascular coats of the brain, coexistent with an hypertrophied heart, and with structural changes in the kidneys.

Dust.—So important is the part played by dust in the phenomena of nature that without it there would be no more fogs, no clouds, no rain, and the three hundred and fifty tons of sulphur thrown into the atmosphere every winter day in London would not without dust suffice in accounting for the density of the fogs. One of the most brilliant discoveries of our day is the numbering of the dust of the air. "The gay motes that people the sunbeam" have been mechanically numbered. It has been computed that in ordinary dry air there are more than two millions of dust particles in the cubic inch, and in an ordinary room there are no fewer than eighty-eight millions. In short, no less than six thousand organisms per cubic yard have been counted in the air of a bedroom, and it is estimated that in a fairly healthy locality a man must breathe, along with the fifteen cubic yards of dusty air, in twenty-four hours, about forty thousand baneful bacteria.—*Med. Press*, April 21, 1889.

Hopkins (W. B.) on Organization and Absorption of Sterilized Dead-bone Dowels.—The author shows the effects of retaining for various periods ox-bone dowels in contact with living bone. The experiments demonstrated that organization of the dead bone readily occurs. His conclusions are as follows:

1. That when dead bone is placed, under favorable circumstances, in contact with living bone, it undergoes organization. When, on the other hand, it is acted upon by periosteum it is absorbed, and when placed in the medullary cavity, in not too large bulk, organization, combined with absorption, takes place.

2. That these processes go on perhaps most actively between the fifth and eighth week, and are not necessarily associated with any inflammatory action.

3. That, therefore, where these dowels are employed to pin together fragments of bone after fracture, to fix the extremities of bone after resections, or for any other mechanical purpose in surgery to which they are adapted, they may be relied upon to do their work for a period of one month or six weeks, and hence to give ample time, as a rule, for union to occur. After this, their presence being no longer required, they gradually lose their identity in surrounding bone, and disappear.—*Med. and Surg. Reporter*, July 27, 1889.

Jackson (A. R.) on Injuries of the Bladder during Laparotomy.—The author's conclusions are drawn from a study of sixty-seven cases. When it is known at the time of operation that the bladder has been cut or torn, Dr. Jackson recommends that the opening should be at once closed with a continuous suture of cat-gut or fine silk, applied so as to invert the edges of the wound and bring together the serous surfaces. A permanent catheter should be used during the first two days. After the expiration of that time, its constant use is usually unnecessary; and, if the wound is small—less than an inch in length — the instrument may be subsequently dispensed with. If, however, the wound is large—exceeding two or three inches—the bladder should be artificially emptied during three or four additional days. In all cases the catheter should be used as long as the urine contains blood.

In the cases in which urine appears through the abdominal wound subsequently to the operation, at a time and under circumstances which may make it dangerous or inexpedient to reach the seat of the injury of the bladder, the catheter ought to be used, either continuously or at short intervals, for the purpose of lessening the amount of urine which escapes through the fistula, and thus aiding in the closure of the latter. If, however, the fistulous opening shows no disposition to close after

two or three months, the edges should be freshened to the depth of half an inch or more, and stitched together.

In exceptional instances it may be expedient to affix the wounded edges of the bladder within those of the abdominal incision, in the manner detailed by Thomas and others; but as this plan must interfere to some extent with the subsequent contractility of the bladder, it is not to be commended as a usual practice. The suturing and "dropping" of the vesical wound is the better method.—*Med. and Surg. Reporter*, July 27, 1889.

Benham (F. L.) on Chloroform and Alcohol.—A boy was admitted a few years ago into the St. Marylebone Infirmary, with periostitis of nearly the whole of the shaft of one femur, and an enormous abscess in connection therewith formed a large swelling, occupying nearly all the length of the thigh. The boy was very ill, pale, and emaciated, but the abscess was speedily opened, under chloroform, without any ill effects. A few days afterward, the patient being already better, another slight operation was required under an anæsthetic. Chloroform was again used; but before he was fully under, and before the operation had been begun, respiration stopped, he became collapsed, and only came to after performance of artificial respiration for many minutes. The operation was abandoned on this occasion.

In the further course of the case, amputation of the thigh became necessary, and was performed under chloroform without any accident. Some time later, chloroform was again given in order to open a small sinus; but he became collapsed and appeared moribund just as on the second occasion, and was again revived with difficulty.

Being puzzled why the same anæsthetic should behave so differently on different occasions in the same patient, I made inquiries as to his condition at the various times. It certainly did not depend on his general health; but I ascertained that on the first and third occasions, a dose of brandy and water had been administered shortly before the operation; on the second and fourth, this had been omitted. A slight subsequent operation being necessary in the stump shortly afterwards, the precaution of giving brandy beforehand was duly taken, and this time no evil consequences happened.

Since this case I cannot call to mind any untoward effects at any time in which I know alcohol and chloroform have been given together.—*Br. Med. Jour.*, July 20, 1889.

Mitchell (S., Jr.) on Castor-Oil as a Menstruum for Cocaine.—Mr. H——, aged fifty, whom I was treating for chronic aural catarrh, was suddenly attacked with herpes zoster, covering the whole left side of the head from the temporal ridge to the occiput. Nearly the first vesicle to form was in the conjunctiva of the upper lid of the left eye. It was attended with much pain, great congestion of the whole palpebral and ocular conjunctiva, contraction of the pupil, and sluggishness of the iris. Atropine and cocaine were employed during the whole course of the disease, and the eye thus kept quite comfortable, until the disappearance of the vesicles from the head. As they healed, leaving deep and painful cicatrices, the one in the conjunctiva healed also, leaving a hard cicatrix that at once assisted in forming an ulcer in the lower margin of the cornea, as large as a kernel of wheat, that steadily grew deeper and more painful, despite all remedies employed. At the end of a week there was well-marked chemosis, together with deep-seated and constant pain. At this juncture it occurred to me to try a drop of castor-oil in the eye, if possible by its use to mitigate the terrible rasping the hard cicatrix was inflicting upon the cornea; then the happy idea suggested itself to combine cocaine with the oil. A five per cent. solution was made, dissolving the cocaine in the oil by means of gentle heat. A few drops of this were instilled into the eye, with almost magical effect. Pain was at once greatly mitigated, the chemosis disappeared, the cornea cleared up, the ulcer began to heal, and my patient grew happy and smiling. All other remedies were discontinued, recovery being rapid and complete.—*Med. Record*, Aug. 4, 1889.

Beach (H. H. A.) on Copaiba in Surgery.—Some years ago, while reading the interesting description of "Medical, Surgical, and Anatomical Cases," published by Lawrence Heister, in London, 1755, I was much impressed with the importance he attached to the balsam of copaiba in his dressings, and determined to test the drug in that capacity. It was accordingly applied to an indolent granulating surface, by first saturating charpie with the balsam, and after squeezing out the superfluous balsam, bandaging the charpie upon the

ulcer. The unusually rapid growth of a handsome bed of rosy granulations, ready for the grafting process, was so clearly attributable to its use, that I continued to employ it, and finally adopted it as regular dressing to granulating surfaces in my hospital wards. It is simple, cheap, quickly prepared, and most satisfactory in its results. Its use has gradually spread to the wards of my colleagues at the hospital, and it is now an accepted dressing; being especially adapted to the flat, pale, granulating surfaces that commonly result from avulsions of the scalp, extensive burns and scalds, also for the cavities after operation for removal of necrosed and carious bone. It has succeeded in raising healthy granulating surfaces for grafting after other stimulating applications had failed. At the hospital it is applied with cotton-waste instead of charpie. The waste can be easily picked apart and cut into short bits by convalescents. The porous nature of the dressing permits a ready absorption of pus and of its partial disinfection by copaiba, which imparts a fragrant balsamic substitute for the sourish odor of pus partly decomposed. On the chances that its activity as a dressing depended upon the copaivic acid which it contains, I have also applied that substance with a negative result.—*Boston Med. and Surg Jour.*, August 8, 1889.

Martin (S.) on Proteid Poisons, with Special Reference to that of the Jequirity.—The conclusions arrived at regarding the jequirity poison] are thus summarized:—

1. The toxic action of the jequirity (abrus precatorius) resides in two proteids: a globulin and an albumose.

2. Both these proteids produce nearly the same effects, namely, local œdema and ecchymosis at the seat of inoculation, with ecchymoses in the serous membranes, and gastro-enteritis, the blood in many cases remaining fluid. The general symptoms are a gradual sleepiness, ending in coma, with rapid onset of rigor mortis.

3. That both portions have a remarkable lowering effect on the body temperature; the globulin, at the same time, producing rapidity of breathing, while the albumose does not have this effect to the same degree.

4. That the activity of both proteids is destroyed by a temperature below the boiling point of water; the globulin between 75° and 80° C., and the albumose at 85° C., while temperatures below these points but above 50° C. diminish the poisonous activity.—*Br. Med. Jour.*, July 27, 1889.

Carbolic Acid Discarded as a Disinfectant.—According to Dr. George Buchanan (*Australasian Med. Gaz.*, June, 1889), the medical department of the government of Antigua have ceased to use carbolic acid as a disinfectant, and in practice employ only heat, perchloride of mercury, and sulphurous acid. This decision has been arrived at after practical experiments as to the effect of different disinfectants upon various infectious material.

Meighan (T. S.) on a Case of Argyria of the Conjunctiva.—Dr. Meighan remarked that this case was interesting as showing the discoloration of the conjunctiva caused by the long use of nitrate-of-silver solution. Cases of this kind are not met with so frequently. The patient is an elderly woman, who complained of watery and inflamed eyes six years ago, and used nitrate of silver drops to her eyes, at that time, for about six months. Both eyes show blackish discoloration of the conjunctiva, and the lids and conjunctiva are flabby and have no elasticity. A piece of conjunctiva was excised, and specimens of it placed under the microscope show that the epithelium is not discolored, but the layer of tissue below the epithelium is stained a dark olive-brown color. This layer is probably the elastic-fibre layer of the conjunctiva.—*Glasgow Med. Jour.*, June, 1889.

Campbell (H.) on Eczema Caused by Iodoform.—Mrs. W—— suffered from an inflamed bursa near the elbow-joint, which was opened antiseptically and dressed with iodoform gauze. A violent attack of eczema ensued, spreading over the whole of the limb. The eczema was cured by oleate-of-zinc ointment. The bursa, having filled a second time some months afterwards, was opened and dressed as before, with a like result—namely, an attack of eczema. On discontinuing the iodoform gauze and dressing with oleate-of-zinc ointment, the attack soon passed off. On a third occasion, before the wound had thoroughly healed, the scab was accidentally removed. Iodoform ointment was inadvertently prescribed, and eczema appeared for the third time. It would seem in this case that iodoform was the exciting cause on each occasion of the eczema.—*Lancet*, April 6, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON M.D.

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LEADING ARTICLE.

SURGERY OF THE SPINE.

The interest which is being felt in operative measures for the relief of pathological conditions of the spine seems to warrant a brief review of some of the recent papers on the subject.

Dr. J. William White, of Philadelphia, read a valuable paper on this subject before the Surgical Section of the American Medical Association, at Newport, in June of this year. The full text of the paper I have not seen published, but the following abstract, which we made at the time (*Med. Record*, July 6, 1889), may be used as an introduction to the subject.

Dr. White divides the spinal troubles which may necessitate surgical interference into three classes: traumatisms, caries, and neoplasms. He reviewed the history of the surgery of these conditions, gave the details of two cases in which he performed resection of the spine, and reached the following conclusions:

1. The objections urged against operative interference in spinal traumatisms were partly theoretical (hemorrhage, frequency of absolute destruction of the cord, pressure from inaccessible fragments of bone, etc.), and have been shown to be unsupported by clinical facts. They were largely due to a well-founded dread of (*a*) the shock, in the cases operated on in pre-anæsthetic times; and (*b*) consecutive inflammation, suppuration, and pyæmia in pre-antiseptic periods. The later results, which now constitute our only safe basis for generalization, are distinctly encouraging, and resection of portions of the vertebræ in fractures, possibly even in dislocations, should be recognized as an eminently proper operation and, in suitable cases, altogether warranted by the facts in our possession; and further, such cases are by no means rare or exceptional.

2. There can be still less doubt that the testimony of both pathologists and practical surgeons indicates that the cause of the paralysis of Pott's disease is, in many instances, an extra-medullary proliferation of connective tissue, assuming the density and proportion of a neoplasm, occupying the space between the dura and the interior surface of the laminæ, not apt to be associated with intra-medullary changes or with destructive degeneration of the cord, and very frequently removable by operation.

3. Every case of focal spinal lesion, thought to depend on a tumor, and not distinctly a malignant and generalized disease, should be regarded as amenable to operative interference, no matter how marked the symptoms of pressure may be, nor how long continued.

4. The method of extension, as recently revived, is well worthy of preliminary trial in the first two classes, and in obscure cases thought to belong to the third class. It has not yet been tried in a sufficiently large number of cases to establish its exact limitation, but it is unquestionably a therapeutic measure of vast importance in spinal injury and disease.

It is customary and proper, in deciding

upon any serious surgical procedure involving risk to life, to consider well the prospects of the patient in the event of non-interference, and to be largely influenced by them. Looked at in this light, the operative surgery of the spine as regards traumatisms, caries, and neoplasms may fairly be said to have a rapidly widening field, and to deserve more serious and careful consideration by practical surgeons than it has received for many years.

We make no apology for making extended abstracts from another paper which we have just received and which may not come to the notice of many of our readers, namely, Spinal Caries: Operative Treatment by De Forest Willard (Transactions of the College of Physicians of Philadelphia).

Dr. Willard considers the operative treatment of spinal caries under three heads:

1. Evacuation of pus.
2. Erasion or removal of caries bone.
3. Vertebrectomy or excision of the lamina for the relief of pressure paralysis.

When there is doubt about the presence of an abscess, when the abscess is very small, and when it is still very deep beneath the skin the aspirator is employed. If pus is found it is drawn off, and 15 to 30 grains of iodoform dissolved in glycerine and distilled water, 1 to 3, is injected. Ten days later, or after a longer delay, provided the abscess does not become distended, the sac is freely opened under strict antiseptic precautions, the pus evacuated, a drainage-tube inserted and the sac thoroughly irrigated with hot sublimate solution, 1 : 2000.

Erasion or removal of carious bone has been practised by Treves, Boeckel, Israel, Reclus, Ashhurst, and others. The operation of Treves (*Med.-Chir. Trans.*, vol. lxvii., 113, 1884–5) is considered and the following objections made:

a. That a sequestrum is rarely present, and if so, would be situated in the body of the vertebra.

b. That it would be impossible to reach the body, save in the lumbar region, without the sacrifice either of the articular process or a portion of several ribs.

c. In caries it would be almost impossible to judge of the exact amount of devitalized bone, and, as in other osseous structures, the process of removal with gouge would certainly destroy the underlying layer of bone, and thus become a fresh source of osteitis.

Pressure upon the cord may be occasioned: 1st. By the sharp angle in front, resulting from the rapidly disintegrating bodies of the vertebræ; 2d. By inflammatory outpouring of ossific matter due to caries of the posterior part of the vertebral body without breaking down of the shell; 3d. By connective-tissue infiltration around the theca; 4th. By a superabundance of caseous material about the cord.

Macewen justly claims that the spinal membranes and the cord itself can be exposed, and that neoplasms and encroachments upon the lumen of the canal may be removed therefrom without unduly hazarding life, and that the old objections that such operations are full of danger from hemorrhage and were unprofitable and unsuccessful, have certainly been thoroughly disproven, and that we are now able to offer a measure of success to a class of hitherto hopeless cases. (*Brit. Med Jour.*, Aug. 11, 1888).

Of course, the operation will not be attempted until extension, rest, and fixation have failed to bring about relief.

Dr. Willard refers to papers in the following journals: *Brit. Med. Jour.*, Aug. 11, 1888; *Glasgow Med. Jour.*, 1884, xxii; *Glasgow Med. Jour.*, 1886, xxv.; *Med. Contemp. Napoli.*, 1884, i.; *Lond. Lancet*, July 14, 1888; *Brit. Med. Jour.*, Sept. 22, 1888; *Brit. Med. Jour.*, 1888, i.; *Am. Jour. Med. Sciences*, Dec., 1888; *Internat. Encyclo. Surg.*, 2d edition, vol. iv., and draws the following conclusions:

1. Improvement from pressure paralysis in vertebral osteitis is common, and may be confidently expected when extension and fixation can be properly carried out, provided motion and sensation have not been entirely absent for many months, and when serious cord changes have not occurred. Hence an operation should not be undertaken until these measures have been presistently tried and proven ineffectual.

2. Vertebrectomy for the relief of pressure in spinal caries is still most emphatically in its experimental stage.

3. The operation, even if effectual in relieving the pressure upon the cord by permitting posterior expansion, or from removal of bony or inflammatory growths, yet promises no certainty of permanent relief, since degeneration of the cord may already have been far advanced.

4. Early operation would doubtless be more successful, as it might antedate the cord changes; but our present diagnostic facilities do not permit us to distinguish accurately these cases from those in which a less serious form of treatment would be followed by the rapid regain of lost power. Hence early operation is undesirable.

5. Pending further knowledge, we can say, however, that the operation is permissible where, after persistent treatment by suspension and fixation, complete motor and sensory paralysis, with spastic rigidity of the muscles, exists, together with exaggerated reflexes which have been present, but which have after a time subsided or been lost.

W. Arbuthnot Lane has recorded (*Brit. Med. Jour.*, April 20, 1889) the operation upon and recovery of so characteristic a case of Pott's paralysis that we will report the case in full:

H. S., aged 7½, was admitted into Job Ward under my care on February 4, 1889. His father suffers from cough and hæmoptysis. He has lost three children with chest complaints. There is also a phthisical history in the mother's family. The boy had bronchitis every winter since birth. He had scarlatina when four years old, from which he recovered perfectly. Eight months afterwards he became weak in his legs, but nothing abnormal was observed in his back. This weakness gradually disappeared, and he was able to run about and attend school.

In January, 1888—thirteen months ago,—his parents observed that his back was prominent between the shoulder-blades. He complained of no pain, either when the lump was pressed upon or on his moving about. By the advice of a medical man he was kept on his back. In March the parents observed that he was unable to move his legs; and in April, when his legs were extended they became suddenly and spasmodically fixed in that position, the feet being forcibly pointed. He was able to control his motions more or less perfectly, and he was conscious of a desire to micturate; it was, however, necessary to attend at once to his wants, otherwise he passed his water into the bed. He never complained at any time of pain, either in the trunk or lower extremities.

On admission, a very abrupt and prominent curve was observed to occupy the dorsal region immediately above its centre, the spinous process of the fifth vertebra apparently forming the angle. There was no pain on pressure, nor on causing the boy to flex or extend his column. The deformity did not occupy a median position, but lay slightly to the right. Consequent upon this assymmetry and upon the existence of this curve, the pelvis had undergone a marked rotation around an antero-posterior, and to a less degree around a vertical, axis, so that the vertical axis of the sacrum, if prolonged, passed through the lower angle of the right scapula, and the crest of the right ilium was an inch below the horizontal level of the left. He is unable to make any voluntary movement of his legs, but alters their position with his hand. They feel cold to the touch, and, though well covered in blankets the whole of the lower portion of his body seems of an abnormally low temperature. His legs can be flexed, and when in that position they can be moved through a considerable angle without any very marked resistance being offered to the movement. On gradually extending them, at a certain degree of extension the muscles of the whole leg become suddenly violently contracted, and the leg and foot are retained in a condition of extreme over-extension. While this spasm is taking place, the patient experiences no discomfort, and the abdominal and intercostal muscles below the level of the deformity display no spasmodic movement. The abdominal and intercostal muscles act normally in respiration. I may say that the father states that the spasmodic contraction of the muscles of the leg while in the extended position is not so violent as it was two months ago. It is not possible to obtain any plantar reflex. The knee-reflex is exaggerated. There is no ankle-clonus. Though the patient can distinguish the point touched, it is apparent that he feels much less distinctly than normal, and that the sense of pain is diminished in the same proportion as that of touch. It is also apparent that this diminution of sensation is more marked in the feet than it is in the thighs and lower part of the trunk. Some resistance is offered to abduction as well as to adduction of the legs. The patient does not appear to experience any pain or discomfort while the legs are being moved, or while they are in a position of rigid extension.

The child coughs frequently. He does

not fill the apices of his lungs during respiration, which is feeble, and there are a few *rdles* to be heard in both bases. He is in the habit of wetting the bed; but whether this resulted from want of attention or not it was difficult to determine. The urine was acid, sp. gr. 1025, no deposit, no albumen, and no blood. The boy was kept quiet in bed for several days, and his temperature, which ran up for several days for a couple of degrees in the evening, varied but very slightly subsequently. His parents were very poor, and there appeared to be no sign of any improvement in the condition of his lower extremities, but, on the contrary, their state was becoming progressively worse. His family history was extremely bad: besides that, he was physically very feeble indeed. Considering these circumstances, I concluded that the only hope of preserving the boy's life was by putting him on his legs and placing him under more favorable circumstances, both as regarded hygiene and diet, than it was possible to do while he was in this helpless condition. I therefore determined to expose the child to an operation which, though comparatively trifling to a more vigorous subject, would be accompanied by some risk to one in his very enfeebled condition. The parents willingly accepted the risk.

Consequently, on February 15th the operation was performed, every care being taken that the child was kept warm during it. The soft parts were rapidly removed from the spinous processes, laminæ, and inner portions of the transverse processes, and the spinous processes and laminæ of the fourth, fifth, and sixth dorsal vertebræ were removed with bone forceps. The spinal canal being opened, the dura mater was exposed, there being no granulation or cicatricial tissue obvious, nor was there any of the fat which normally exists in this position. The dura-matral sheath when first exposed was flaccid, and the cord felt thin and soft; at first it did not pulsate, but after a time the pulsations, though slight, were obvious. The body of the fifth dorsal vertebra appeared to be abnormally near the laminæ of the adjoining vertebræ, and it appeared to me that the cord had been forcibly compressed between these bony points. As there was nothing else to be felt there was no indication to proceed further. The wound was then closed, a small drainage-tube being fastened into the lower end of the wound, and a dressing of alembroth wool applied. The dressing was changed on the following day, when the drainage-tube was removed, The wound did not require another change of dressing.

On the evening of the 15th his temperature rose to 101.2°, and his pulse was 130, but on the following morning the temperature was normal. To prevent the dressings being wetted his urine was drawn off at intervals during the day. He knows when his bladder is full, but he cannot void it as he did before the operation. On February 18th he acquired control over his bladder, and it became no longer necessary to continue the use of the soft rubber catheter, which he objected to very much. On the second day after the operation the spasmodic contraction of the muscles of the leg in the extended posture had disappeared. Besides that, they felt warmer to the touch, as did the whole of his trunk.

On February 19th, four days after the operation, he was able to move his legs slightly in response to slight stimuli. He does not seem to be aware of the extent to which he moves. It is also obvious that he feels very much more distinctly than he did before the operation. For instance, it was possible to tickle the soles of his feet very vigorously without causing him the slightest discomfort, though he was conscious of the fact, but now tickling causes him to remove his feet and also produces discomfort. The daily improvement in power in his legs was gradual, and he soon ceased to wet his bed. He lost his cough completely and gained flesh rapidly.

On March 19th—when this paper was sent for publication—the child could move his legs freely, and we are only waiting till the cicatrix is sufficiently consolidated to apply a poroplastic jacket and to get him up.

White (Notes from Clinical Lectures, *Univers. Med. Mag.*, Aug., 1889), on Dec. 12, 1888, in a patient 23 years old, suffering from Pott's paralysis, removed the arches of the tenth and eleventh dorsal vertebræ. The patient died thirty-nine hours after the completion of the operation, having lost but little blood, but complaining greatly of pain in the back. He showed an extraordinary variation in the temperature, taken simultaneously in the axilla, under the tongue, and in the rectum. For

hours the extreme difference was as much as 8° or 9° Fahrenheit, the thermometer constantly showing 95° beneath the tongue, 102.5° in the arm-pit, and 104° to 105° in the bowel. This continued until death.

The autopsy disclosed a hopeless condition (enormous encapsulated tubercular spinal abscess and tubercle of lower lobe of right lung).

John Duncan (*Edinburgh Med. Jour.*, March, 1889) operated, Oct. 31, 1888, on a boy 11 years old suffering from Pott's paralysis. The patient had a marked angular curvature in the mid-dorsal spine. The spines and laminæ of the fourth, fifth, sixth, and seventh dorsal vertebræ were removed. The membranes were found adhering to the bones by granulation texture, which was easily scraped from them by means of a sharp spoon. They then appeared tolerably white and smooth. Only after this was done could a faint pulsation be observed in the cord, but the canal above and below was found quite free, and in no way compressing the contained viscus. A plaster-of-Paris jacket was applied. On February 15, 1889, he was steadily improving. He was being kept mainly in the horizontal position. His sensation was, at that time, very good, but he still walked with a spastic, jerky gait.

Abbe's case (*Med. Record*, Feb. 9, 1889), although presenting no tubercular bacilli on microscopic examination, had many of the appearances of a tubercular growth.

The patient was 22 years old, and had been paraplegic for about four months. He had annoying, uncontrollable twitchings of the legs, which were cyanotic when allowed to depend from the bed. The spine became rigid and very painful; the legs absolutely anæsthetic; abdomen tender and hyperæsthetic. A wasting hectic had set in. On May 10th he was growing rapidly weaker; had constant intercostal pain in the lower ribs, with girdle pains about the limiting line of disease. There was involuntary muscular twitching, with increasing incontinence of urine and fæces. By May 25th, affairs had gone from bad to worse, the man lay in an apathetic condition, suffering from the slightest motion of the spine, and with girdle and intercostal pains unabated. The presence of an active hectic led one to fear a serious general infection. A final consultation was held May 29th, at which Drs. Seguin, Weir, Peters, Kinnicutt, Bull, Ridlon, Murray, and myself were present. Previous explorations of the swelling had shown nothing, but to-day a drop of thick, shreddy pus was obtained, and on the following day I operated.

May 26th.—Under ether, an incision was made, six inches long, close to the spines, from the sixth to the twelfth dorsal. The laminæ being uncovered, some thick broken-down tissue and pus were scraped away. The laminæ were already bare of periosteum, and the spines and laminæ of the eight, ninth, and tenth were cut away by rongeurs. This revealed a dense mass of tissue and desiccated pus occupying the entire calibre of the canal, and extending up and down in all two and a half inches. This compressed the cord tightly against the anterior wall. It was rapidly and thoroughly removed by a sharp Volckman spoon, until sound bleeding tissue was left on every side. The cord was not seen to pulsate. The cavity was packed with iodoform gauze—after bichloride irrigation—and an antiseptic dressing and plaster-of-Paris jacket applied.

On the eighth day, sensation began to return. In the fourth week he began to move his left leg and the toes of the right. His fever rapidly left. Pain disappeared, and appetite returned. In six weeks he moved both legs well. In ten weeks he went about in a rolling-chair. The third month, walked with crutches. At four and a half months, walked pushing a chair.

It is now eight months, and you see he walks well without support, is stout and hearty, and since the operation absolutely without fever, or evidence of tuberculosis. The tumor tissue was examined for bacilli, but nothing but cellular tumor elements and pus found.

The clinical evidence leads me to believe the neoplasm began between the theca and the posterior arch of the vertebræ, and then broke down, involving the bone. The bodies of the vertebræ are perfectly sound.

Fenger (*Western Med. Report*, July, 1889) recorded the removal of a spindle-celled sarcoma from the cord.

On the 5th of June Dr. Fenger cut down upon the fourth dorsal spine, making an incision which laid bare the spinous processes of the third, fourth, and fifth dorsal vertebræ, and after cutting away the spines

of those three and the lamina of the fourth and fifth, no tumor could be found pressing upon the cord. Externally the membranes of the cord and the fat surrounding it looked normal, looked as if we had missed the diagnosis.

Having made an incision through the dura mater, the cord, upon inspection, looked normal, but upon passing the fingers over the cord there was a distinct enlargement in its posterior half, and a longitudinal incision along the posterior median line of the cord revealed a tumor nearly two inches long, conical at both extremities, largest in the middle. It has been found to be a large spindle-celled sarcoma. The tumor was easily enucleated and seemingly without hemorrhage, and then the dura mater was almost closed, leaving slight capillary drainage, and the wound closed in an antiseptic manner. The man had perfect paraplegia after the operation. For two days after the operation his temperature did not exceed 101° F., ran from 99 to 101° F., and then it rapidly developed to 103½° F., and he died of scepticæmia on the fifth day after the operation.

Dr. R. H. M. Dawbarn (*N. Y. Med. Jour.*, June 29, 1889) operated on February 27, 1889, on a patient 29 years old, who had sustained a fracture of the spine on August 31, 1888. With intention to replace the portions of bone removed, an "H"-shaped incision was made, and the laminæ sawed through on either side. The laminæ of the eleventh dorsal, however, was so firmly adherent that the rongeur was resorted to, and the replacement of the bone fragments abandoned. The posterior arches of the 10th, 11th, and 12th were dissected away; the 1st lumbar arch proved normal and was not removed. The theca did not pulsate at all, and seemed adherent to the cord. Just below the 11th lamina was evidence of an old transverse rupture of this sheath, which had reunited, but with slightly overlapping edges. No break in the cord proper could be appreciated by the sight or the finger, and a curved probe passed at intervals gently beneath the theca could not find any bony point on the anterior wall pressing it—excepting a slight angle of perhaps 15°, apparently made by fracture of the body of the 12th vertebra, and this was not acute. The weak condition of the patient and the already prolonged operation prevented the opening of the theca. The patient recovered from the effects of the operation, and was somewhat improved as regards his paralysis.

Dr. Lampiasi, of Trapani, related the case of a man, aged 28, who was thrown from his horse, which fell on him. There was sensory and motor paralysis, with loss of control of the bladder and rectum. There was some prominence of the twelfth dorsal vertebra. An incision was made over the spinous process, and the bone exposed. There was fracture of the left superior articular process and of the *left* transverse process of the twelfth vertebra, with luxation backwards of the right upper articular process so as to override the lower articular facet of the vertebra above. The two superior processes of the twelfth vertebra were resected, and the dislocation reduced. There was no improvement in the symptoms, and death occurred six days after the operation. At the *post-mortem* examination there was found rupture of the lateral ligaments, detachment of the intervertebral disc of the twelfth vertebra, which remained adherent to the eleventh, and projected two centimetres into the spinal canal, where it pressed on the front part of the cord.—*Br. Med. Jour.*, May 4, 1889.

Reports of two cases of Fracture of the Spine Treated by Trephining, by Mr. Herbert W. Allingham, may be found in the *Lond. Lancet*, July 1, 1889.

The first, a man 31 years old, sustained a fracture of the laminæ of the sixth dorsal vertebra. The cord looked bruised, but pulsated freely on the pressure being removed; at the same time it seemed to be curved backwards, this being probably caused by some displacement of the body of the sixth vertebra. The theca was not opened.

The patient recovered from the operation, but the paralysis, though somewhat improved, remained when he passed from under observation.

The second case, a woman 21 years old, sustained a fracture of the laminæ of the fourth dorsal vertebra. The spinous processes of the third, fourth, and fifth vertebræ were removed, and the cord exposed for about four inches. The cord was much bruised and crushed, and a spicula of bone projected from the right side of the body of the fourth vertebra, the cord pulsating down to this point, but not below. Upon the spicula being removed, the cord commenced to pulsate below. The theca was opened. The patient recovered from the

operation, and the paralysis was somewhat improved. She died seven months later, and the cord was found to be almost divided into two parts, both ends gradually tapering down to a fine point.

Although these cases have not terminated in he way I hoped, yet I have learnt the following facts, which may be of use in considering the question of treatment of these cases of spinal injury: 1. That by trephining it is evident from these cases that inflammatory ascending changes are prevented. 2. That no bad symptoms follow from opening the spinal dura mater and allowing the cerebro-spinal fluid to flow out. 3. The operation, although tedious, is not a difficult one to perform, and does not in any way diminish the chance of recovery. Hemorrhage is easily controlled, and the wound heals quickly. From the above-mentioned facts, I beg to suggest that in all cases of spinal injury followed by paralysis and loss of sensation trephining be done, so that, if the symptoms be caused by the pressure of blood or displaced bone, they may be removed before ascending and descending changes come on, and thus give the patient a chance of complete recovery.

Mr. John Duncan (*Edinburgh Med. Jour.*, March, 1889), reports operations for relief of paralysis on three cases of fracture of the spine. The first, a man 19 years old, fractured the arches of the tenth, eleventh, and twelfth dorsal vertebræ, and the body of the tenth was displaced forward, with relation to the eleventh, about a quarter of an inch. The membranes were uninjured. The wound healed, but the paralysis remained the same at the end of six months.

The second, a man 34 years old, sustained a fracture of the third lumbar spine. It was fractured through the laminæ, and removed. The arch of the second was also removed, and it was seen that the body of the second was displaced forward to the extent of nearly an inch with relation to the third. The sheath was opened and some blood-clots and bloody fluid evacuated. By manipulation the vertebræ were replaced, and a plaster-of-Paris jacket applied. At the end of two days the wound was healed throughout. The temperature was normal, and the pulse good. Sensation had returned in the legs to considerably below the knees. During the night he was restless, and towards morning, having become quickly cyanosed, he died. The autopsy revealed the left leaf of the diaphragm largely lacerated, and the stomach (somewhat dilated) and the great omentum lying in the left pleural cavity. The left lung was compressed, and the heart displaced to the right. There was a fracture at the base of the seventh cervical spinous process. The lumbar region was found as described.

The third case, a man 21 years old, was struck, when in the stooping posture, by a mass of coal, estimated at 10 cwt. Five weeks later, when the extravasation had been removed, the fractured spine and laminæ of the second lumbar vertebra were removed. The parts were found to be so matted together as to be scarcely recognizable, but after the removal of two other arches it was seen that the whole of the first lumbar vertebra was displaced forwards about an inch, and that the cord was torn half through and made two bends, each perfectly rectangular, at the upper surface of the second lumbar vertebra, following the line of fracture.

At the end of sixteen days (when the case was reported) the cerebro-spinal fluid still flowed—estimated about two ounces each day. The temperature was nearly normal, and the patient otherwise well, but the paraplegia was unaltered.

I cannot do better than close this review by an abstract of the valuable paper by Dr. N. P. Dandridge, of Cincinnati, read before the Surgical Section of the Am. Med. Association, at Newport, on June 25, 1889 (*Med. Record*, June 29, 1889. For full text of paper see *Jour. Am. Med. Association*, July 13, 1889) on Surgical Interference in Fractures of the Spine.

The recent interest in the surgery of the spine dates from the removal of a tumor of the cord by Horsley, and the operation by Macewen for the relief of paralysis in Pott's disease.

In applying the results to fracture, it must be remembered that, in cases of tumor, operation is the only method of treatment which promises any benefit. In Pott's disease paralytic symptoms often disappear, even after long continuance, and in one personal case, complete paraplegia lasting for more than three years and a half was finally relieved. Very often, however, the thickening of tissue making pressure on the cord, becomes a permanent tumor growth, and removal

by the knife offers the only prospect of relief. The result of trephining the spinal canal, in these cases, has given most brilliant results; recovery taking place in one case of Horsley's after six or seven years of paralysis, and in one of Macewen's after two years. The analogy of these cases and fracture must be applied with caution. In fracture the damage done to the cord is often immediate, and is often due to continued pressure from narrowing the canal by displaced bone. Following fracture, however, we may have pressure produced by inflammatory products, which may assist in continuing the symptoms. In discussing the propriety of operation it is proper to consider the results obtained in fracture of the spine without operative interference. Burrill has shown that twenty-one per cent. survive, and one half of these make satisfactory recovery. It is apparent from these figures that a considerable number of cases are brought to a satisfactory termination, and in these the symptoms of paralysis, bedsores, and incontinence do not show any evidence of improvement for weeks after the injury.

In five cases of fracture of the dorsal spine under the writer's care, the plaster jacket was applied in three soon after the injury—in two with satisfactory result and complete disappearance of paralysis. In the third, the recovery was only partial. In these cases the plaster jacket was applied by the hammock suspension, as suggested first by Mr. Davy. In one case suspension was employed five months after the fracture, and was followed by marked benefit. The fifth case was trephined, and the tenth, eleventh, and twelfth dorsal, and first lumbar laminæ removed at the end of five months, for the relief of complete paraplegia, cystitis, incontinence of urine and fæces, and extensive bedsores. No apparent immediate benefit followed the operation, but eight weeks later the cystitis had disappeared, some of the bedsores were entirely healed and all were better, and the general condition was improved. In fracture of the spine immediate operation is not indicated, as a considerable portion of cases recover under less dangerous methods of treatment. The continuance of symptoms is an indication for operation, as it has been conclusively shown that the relief of pressure, even after long continuance, may be followed by complete restoration.

CONCLUSIONS.

1. In fractures of the cervical vertebræ, there is indicated immediate reduction of any displacement by extension and manipulation under an anæsthetic, followed by continuous extension and immobilization.

2. In all fractures of the lumbar or dorsal spine, involving the bodies or the arches, reduction is effected, with or without the plaster jacket, by the hammock suspension, preceded, if there is evident displacement, by extension under an anæsthetic.

3. When symptoms indicating injury of the cord persist without improvement, resection is indicated.

4. Immediate operation would be indicated when there is marked depression of the arches with symptoms of paralysis.

5. Long continuance of the symptoms is not in itself a contra-indication to operation.

6. We have, in suspension, the means of alleviating some of the sequelæ of fracture of the spine. JOHN RIDLON, M.D.

THERAPEUTICS.

Macfarlane (A. W.) on the Therapeutic of Senna Pods.—An infusion of senna pods is almost free from taste and smell; certainly it is devoid of the characteristic odor and flavor of "senna." It appears to increase activity in the muscular movements of the whole gastro-intestinal canal, acting quite as much on the colon and rectum as upon the small intestine. It is slower in its action than an infusion of the leaves, but equally certain; an ordinary dose produces without fail one motion, seldom more, of soft consistence, in from eight to ten hours, and without exciting any congestion of the pelvic vessels, or increasing or aggravating hæmorrhoidal or menstrual discharges. It is, in short, a reliable evacuant, free from irritating properties such as cause griping and flatulence; and, if the experience of one case is worthy of mention, it does not appear to be excreted through the milk in the nursing mother, for in one such patient the child was unaffected by its use. Administered regularly for several nights in cases of intestinal torpor, it cleans the tongue, increases the appetite and digestion, and promotes natural evacuation of the bowels, so that the quantity taken requires to be decreased, and eventually it can be dis-

pensed with. The cases in which I have found it most serviceable are those depending upon impaired muscular movements, from defective innervation, usually associated with flatulence and intestinal discomfort. It has also proved useful in cases of hæmorrhoids, and in constipation in children, as well as in the aged. Like all purgative medicines, the infusion acts better in some persons than in others, and also in the same person at different times; but, after a fairly extended experience of its use, I have not been disappointed in its utility in any one case, nor have I been annoyed by any untoward effects. I am not sanguine enough to hope that it will meet the exigencies of every case of constipation, but that it is a real addition to our remedies I cannot doubt. It has afforded me better results than any other medicine I have yet used, exceeding in efficacy cascara sagrada; while its freedom from disagreeable taste is a strong point in its favor.

There are apparently no contra-indications to its use. The dose for an adult is from six to twelve pods; for the young and very aged from three to six. They are best infused in a claret glass of cold water for six or eight hours.—*Lancet*, July 27, 1889.

On Pilocarpine in Deafness.—Dr. Field thinks[1] the remedy useless in senile deafness and attributes the many failures of the treatment reported due to the fact that the patients have been over sixty years of age. He says:

"I would ask the profession to suspend their judgment for a time on this question, as to the efficacy of pilocarpine injections in labyrinthine disease, and even in chronic catarrh of the middle ear without Eustachian obstruction. I have had more successes than failures in my own selected cases, and I am continually hearing of encouraging results from others."

He reports three new cases.

"1. A medical man consulted me some time ago, and said he was so deaf that he was afraid he must give up practice. I suggested he should try pilocarpine injections for six weeks. He now writes (July 7th): 'I used the nightly injections for six weeks, with almost a complete cure; you cannot think how thankful I am for the restoration of my hearing.'

"2. A lady, aged thirty-four, very deaf for fifteen years, writes: 'I am glad to say I have received much benefit from your treatment. I can now hear general conversation and take part in it; I can also hear musical instruments playing in the streets and the minister speaking from the pulpit, and also have less noise in my ears.'

"3. A lady who had been deaf for seventeen years, unable to hear without a trumpet, writes: 'On the first day I was injected I was unable to hear a watch or clock tick. On the ninth day, noticed sound in my own voice; on the fifteenth day, could hear my own watch tick for the first time for eight years; twenty-second day, noticed immense improvement, heard bells, knocks, watch two inches distant from right ear, and faintly at left; fiftieth day, continued improvement; fifty-seventh day, heard sermon with trumpet; sixty-fourth day, heard sermon without trumpet.' She remarks on the general result: 'Immense improvement in hearing; can now hear all the clocks in the house tick. Much easier to maintain conversation with one person. Much more conscious of sounds in the house.'"

Dr. H. M. Jones says in my "Practitioner's Handbook on Diseases of the Ear," is the following: "It is a question if we avail ourselves of the action of pilocarpine as frequently as we should. It is probably the most certain and powerful of all our drugs in cases suitable for its administration, where the reduction of vascular tension is our object, and in which we desire to check effusion and control the tendency to extravasation. These are exactly the conditions in the earlier stages of Ménière's disease and other forms of vertigo in which labyrinthine effusions are threatened. I may add that I first used pilocarpine subcutaneously in labyrinthine vertigo in 1879. I have since (as in a remarkably successful case of typical Ménière's disease, referred to in my 'Handbook' in 1885) repeatedly advised and resorted to the use of pilocarpine in labyrinthine vertigo. My success has been marked in some instances, and failure as complete in others has followed its employment. I may say in conclusion, that notwithstanding my unfavorable relations with this drug in one memorable case, I consider as a reducer of vascular tension, especially in ocular hypertension and effusion, when given subcutaneously in appropriate cases, it stands unequalled, and that prudently administered, it is as safe a remedy

[1] *Br. Med. Jour.*, July 27, 1889.

as any other powerful therapeutic agent we are daily using for other therapeutic indications."

Dr. H. Barrett has [1] used it in four cases. These occurred in the persons of three gentlemen, whose ages varied from forty-five to twenty-three, and one lady, aged twenty-one. In each case the treatment was continued for six weeks, and in each of the male cases material improvement was effected. In the lady's case, he could not find any worth mentioning. It was not merely that he detected improvement in the three male patients by the usual methods of testing, but they expressed themselves as hearing with much greater facility.

His experience with the small number of cases mentioned led him to believe that the full benefit of the treatment could not be gained in a less time than six weeks; and it is probable that in many cases an even longer period would be better.

The Antiseptic Properties of Essences.—In the craze after chemical antiseptics, the value of various essential oils and essences has been somewhat overlooked, and we are indebted to some French observers for a series of observations which show clearly enough that it is by no means necessary to have recourse to dangerous agents in our war of extermination against pathogenic organisms. It has been shown, for instance, that the essential oil of the *cannella alba* is as powerful a germicide as a one per cent. solution of corrosive sublimate, the bacillus of typhoid fever being killed by the former in ten, and by the latter in twelve minutes. A comparison of eucalyptus, pine, and other essences with the antiseptics generally in use, such as boracic acid, carbolic acid, iodoform, etc., is all in favor of the former. Iodoformic ether, so much lauded by Bouchard and others, only comes seventh on the list. An examination of the methods adopted by the ancient Egyptians for the conservation of their dead shows that they were perfectly cognizant of the anti-putrefactive properties of the various aromatic substances, balsams, and pure essences, and employed them with signal success. Moreover, from Hippocrates down to Ambrose Peré, the favorite dressing used by surgeons consisted of various oils, oleo-resins, aromatic wines, and similar antiseptic substances, of which one, at least, has survived to this day in friar's balsam, the compound tincture of benzoin. The famous theriacum of Andromachus, the formula for which has been handed down through centuries from the days of Nero to the present time, in addition to sulphate of iron, powdered opium, and various tannin astringents, contained forty different aromatics. Popular medicine, indeed, has always shown a preference for aromatic plants. It is evident, therefore, that if our forefathers had not grasped the theory of the antiseptic treatment, they at any rate recognized its value in practice. Hygiene and perfumery walk hand in hand, and many of the delicate odors which haunt the steps of our fashionable beauties possess marked disinfectant properties. We find accordingly that in proportion as cleanliness has become a national virtue, the taste for odoriferous products has become modified, and their lavish use is no longer considered to be a proof of good taste.—*Med. Press*, July 24, 1881.

Bruns (H. D.) on the Use of Mercuric Bichloride in a Certain Class of Cases.—A class of children, evidently anæmic and suffering from some fault of nutrition, but in whose cases iron in the various forms does but little good, often come under our observation. These little patients are flabby-faced, fairly plump, usually light-eyed, with fair hair and skins; they are thick-lipped, one or two of the cervical glands may be enlarged, and their incisor teeth are defective, as a rule showing "tidal marks." They are pale and languid, but often mentally bright. In our eye and ear clinics they present themselves with running noses, phlyctenular keratitis or conjunctivitis, blepharitis marginalis or otorrhœa. In a word they belong to that class usually designated by the somewhat vague term "scrofulous." But in many individuals the ear-marks of the so-called diathesis are wanting, and a careless or routine diagnostician would fail to classify them. All that we can observe is that while these children are not thin or puny, they are pale and patently out of health. Occasionally we are at first led to observe the child more closely by the failure of a long-continued course of the ferruginous tonics to do good. In the frankly scrofulous cases we prescribe the syrup of the iodide of iron, cod-liver oil, the hypophosphites, etc., but for my part I must confess with most disappointing results. I have

[1] *Br Med. Jour.*, August 3, 1889.

not time to discuss the much mooted point whether scrofula is the direct descendant of syphilis or not. At any rate it is sure that these patients form a separate group from those whom we point out unhesitatingly as the victims of secondary—inherited—syphilis, little people with swollen tibiæ, interstitial keratitis and Hutchinson's teeth.

Of late years, acting upon a hint dropped by a practitioner of large experience, I have treated all these patients, whether the signs of scrofula were well marked or scarcely discernible, with small doses of bichloride of mercury, *occasionally* combined with equally small quantities of potassium iodide; and with far better results, I believe, than I ever derived from the syrup of the iodide of iron, cod-liver oil, and all that genus. By small doses of the bichloride I mean doses of from gr. $\frac{1}{60}$ to gr. $\frac{1}{30}$, and of the iodide of from gr. j. to gr. ij, repeated twice or thrice a day; and under this regimen we see these children rapidly gain color, flesh, and vivacity.

We may say that the scrofulous body resembles a structure we wish to repair, but cannot, because, although an abundance of new bricks, mortar, and timbers are at hand, we are without means to take out and carry away the old material.

In such a body, I conceive, the nutritive material is present in sufficient quantity and is well supplied to all parts, but those processes by which the old cells are chemically changed, broken down and their detritus removed, are in abeyance. The old inactive cells linger too long in positions that should have been occupied by young and energetic ones, and as a consequence in time the whole organism suffers. There can be little doubt that the lymphatic system is greatly in fault in all this. The introduction of the active agents, mercury, chlorine, iodine, and potassium, into the blood brings about a change in the vital chemistry, and a change, it seems highly probable, favorable to retrograde metamorphosis. These agents also, it seems reasonable to suppose in the light of our present knowledge, stimulate the lymphatic system. Mercury increases the red blood-corpuscles, because it breaks down the old ones, thus making room for new; while at the same time it stimulates the blood-making organs—for the most part, we imagine, lymphatic.—*New Orleans Med. and Surg. Jour.*, Aug., 1889.

Illingworth (C. R.) on the Biniodide of Mercury.—I wish most particularly to call attention to the fact that such is the penetrating power of the iodide of sodium vehicle, that ophthalmia neonatorum may be cured in four or five days with the biniodide in sodic iodide, of the strength of 1 in 3,000, and ringworm with one application of a 1 in 4 solution.

1. *Local uses.*—Precipitated and redissolved by adding a solution of sodic iodide (1 in 4) to sol. hyd. bichlor. (B. P.); corrosive sublimate and chloride of ammonium of each gr. x., water one pint. Thus sol. hyd. bi. ℥ viij; sol. sodii iodidi (1 in 4) ʒ j; mix, and thus prepare a 1 in 1,000 solution. Dilute with ordinary water for the various strengths required. For disinfectant purposes as a spray it may be used pure. Surgical dressing, 1 in 2,000; otorrhœa, 1 in 2,000 or 2,500; ophthalmia neonatorum, 1 in 3,000; alopecia areata, 1 in 500 (by preparing the sol. hyd. bichlor. of double strength, 1 in 500); scabies, 1 in 500; puerperal septicæmia, an injection of 1 in 2,000 (warm), iron internally; scarlet-fever and diphtheria, a spray of 1 in 2,000 frequently (scented, if for children); ozæna, 1 in 4,000 or 5,000 (warm); hay asthma, 1 in 2,000, as inhalation spray and douche (warm); gonorrhœa, 1 in 4,000 to 5,000, with aqueous solution of opium. Then also in the form of a concentrated solution of various strengths. Thus to ʒ ss hyd. biniodid. add ℥ ss sol. sodii iodidi, and a strong blistering fluid is prepared. For the cure of ringworm add three parts of water to a small quantity of this strong solution, and apply once with a camel's-hair pencil. For epulis, inject one or two minims of the 1 in 4 into the base of the tumor once a week (after cocaine) until cured. For rodent ulcer of the face, apply the strong solution to the raw surface twice a week for three weeks and then allow to heal, applying zinc ointment for that purpose. For poisoned wounds, apply the 1 in 4 solution daily until the local symptoms subside, and give iron internally.

2. *Internal uses.*—In mixture, pill, or powder (with sugar). Mixture: Sol. hyd. biclor. ℥ j – ℥ iss; potass. vel. sodii iodid., ʒ ss; syrup. aurant. vel. aq. menth. pip., ad ℥ vj; dose, one tablespoonful every two, three, or four hours; pills, $\frac{1}{16}$ to $\frac{1}{4}$ grain; powders, with two grains of sugar to every $\frac{1}{16}$ grain of biniodide. In meningitis, mixture every two or three hours;

pleuritis the same, with chloral or morphia as sedative for cough, and blisters externally. Neuralgia, mixture with chloral and bromide, five to ten grains of each; acute congestive headache, with quick pulse and flushed face, pill of ¼ grain every four hours, or mixture every two hours; chronic headache the same, three times a day, with double doses of sodic iodide; flatulent dyspepsia, with constipation and disordered liver, pills ¼ grain, one at bedtime; cholera, preventive and curative, $\frac{1}{16}$ grain to ⅛ three times a day, with brandy and ammonia; alopecia areata—to check and destroy,—mixture three times a day; gout, mixture every two or three hours, with chloral and bromide for sleeplessness; iritis, every three or four hours; interstitial corneitis, mixture *ter die;* chronic skin eruptions, mixture; amenorrhœa in pill, with ammonia and ammonio-citrate of iron in mixture; in sleeplessness from chronic alcoholism or heart disease, in pill (gr. ¼) every four hours. In puerperal septicæmia I give the biniodide in pill (gr. ¼) three times a day, besides using it locally. From the curative action in epulis should I think the biniodide would prove of singular service in the destruction of cancers and other malignant growths, by injection into their substance.—*Med. Press*, Aug. 7, 1889.

Chetwood (C. H.) on the Toxic Action of Cocaine.—The patient was about twenty-five years of age, and was afflicted with a stricture of the anterior urethra which it was deemed advisable to cut. About a drachm of a four per cent. solution was thrown into his urethra, and shortly afterward another drachm, most of the first having escaped; so that, in all, not much over one drachm remained in contact with the urethral mucous membrane. An examination by the bulbous bougies had previously been made, hence a possible dissolution in the continuity of the mucous membrane, and a consequent greater absorption, should be taken into account.

Within three minutes after the introduction of the cocaine the patient seemed to be unnaturally nervous and excited, his pupils showed marked dilatation, and the lids being retracted gave him a very wild appearance. His excitement greatly increased, he soon became unruly, so that it took several men to hold him down, against whom he fought wildly and vociferated loudly. His actions resembled what is seen in an attack of acute mania.

Outside of the maniacal symptoms the cocaine manifested its effect in another form, which was an interesting feature, and consisted in tetanic, or tonic, spasms of the muscles, as varying from epileptiform, which is more often met with as a result of cocaine.

At the onset of the attack the patient was on a table, and though he fought and resisted, it could be noticed that both arms were markedly drawn up and the muscles rigid. There was also spasm of the muscles of the thorax, which was apparent from the impaired respiratory movements. In getting upon his feet and attempting to move, he walked "stiff-legged," and the spasms became more acute when he tried to use his muscles; in fact, without assistance he would have fallen down. During the attack the pulse was rather slow, and there was a general pallor of the external surface.

He was given a hypodermic of whiskey and eight minims of Magendie's solution of morphia, and in a few minutes' time became more quiet, and submitted to being put to bed. Within a quarter of an hour the whole attack had passed off, the pupils became normal, the spasms had ceased, and all that remained was a feeling of dizziness, and a vague recollection of having made a disturbance, without any vivid remembrance of what had occurred.—*Med. Record*, Aug. 10, 1889.

Farmer (M. H.) on Sulphonal.—About one o'clock on the morning of June 30th, I was called to attend Mrs. C., æt. 20 years, in her first confinement. She was a woman of vigorous constitution, never having been sick in her life. Although I had but five blocks to walk, the child was born when I reached the house. Having cared for the child and removed the after-birth, the patient appearing exceedingly nervous and irritable, I administered a fifteen-grain dose of sulphonal, and fifteen minutes later went home. Twenty-five minutes after reaching home, I was again hastily summoned by the patient's husband. I repaired to the house at once, and found her with a face as white as a sheet. Radial pulse not perceptible. Respiration eight to the minute. She was bathed in a cold, clammy sweat, and gave every indication of a dangerous collapse. I immediately examined her for hemorrhage, but found none. She rallied in about an hour, under the persistent use of stimulants and hot applications, and has since done very well. —*Weekly Med. Rev.*, July 20, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OCCASIONAL REPORT ON OBSTETRICS.

BY ELIZABETH STOW BROWN, M.D.

Hunt (Chas. C.) on Carbolic Acid as a Disinfectant in the Treatment of Puerperal Septicæmia.—The author strongly advocates in obstetric practice the claims of carbolic acid, either undiluted or in very strong solution, as a local application to the points through which diseased germs find their way into the system—namely, the lesions in the genital tract and the interior of the uterus. The author thinks that the solutions of the various antiseptics that are used for intra-uterine injections are of such strengths as are most favorable to absorption and consequent toxæmia, and hence that in avoiding one danger another not less important may be induced.

It is recommended that the patient be put in the lithotomy position, and the cervix exposed by a bivalve speculum. A douche of sterilized water about 110° temperature is prepared for use at the proper time. An ordinary uterine sound is wrapped with absorbent cotton, until it becomes of proper size, and is saturated with undiluted carbolic-acid solution. Any excess that will be liable to drip is shaken off. With the sound in the right hand, and steadying the speculum with thumb and finger of the left hand, the whole uterine cavity is thoroughly mopped out, until all detritus ceases to come away, and the carbolic begins to be seen returning. To prevent unnecessary cauterization of the posterior lip and vagina, a pledget of absorbent cotton is placed underneath the lip, and of sufficient size to fill up and extend a little below the cul-de-sac. The nozzle of the syringe is then introduced into the uterine cavity, and the water is permitted to trickle down through until all excess of the acid is removed. The speculum is gradually withdrawn, and every abrasion or every denuded surface brought into view is thoroughly cauterized with the acid. A small vaginal douche removes any excess of acid on these abrasions.

The author believes that a cotton-wrapped sound answers all the necessary purposes of a dull curette, and that in most cases of puerperal septicæmia it is a great improvement on any form of metallic curette, as it will effectually remove all detritus with the least possible harshness, and at the same time carry on the process of local disinfection. Carbolic acid is only a superficial caustic; it is an astringent and local anæsthetic as well. It promotes uterine contraction, paralyzes the absorbents, so to speak, shuts up the gaping sinuses, and renders aseptic every part it touches. Absorption of the antiseptic douche which follows the application is prevented by the previous contraction of the uterus and the superficial caustic effect of the acid.

The points which the author's clinical experience with the use of undiluted or very strong solutions of carbolic acid tends to establish are:

I. That it is not attended with danger.

II. That if applied early the temperature is immediately reduced.

III. That it is efficient as a disinfectant; no micro-organisms or spores can live or develop where it touches.

IV. That to apply it effectually and safely we must be guided by the sense of sight as well as that of touch.—*N. A. Practitioner*, July 1, 1889.

Barbour (A. H. F.) on the Light which Sectional Anatomy will Throw upon the Mechanism of Labor.—The movements of the child through the pelvis have been hitherto studied by two methods: theoretically with a fœtal skull and dry pelvis, and clinically on the living subject. A third method of inquiry has been recently introduced—that of making frozen sections. This last method belongs to the last fifteen years, and as yet the results are scanty. The author, in the observations of this paper, indicates the light which sectional anatomy is fitted to throw on the mechanism of labor, and refers to questions which have arisen while declining to fully answer them.

Sections hitherto published have been mostly vertical mesial, but it is desirable that sections should be made in the following directions:

I. Longitudinal sections in one of the diameters of the bony pelvis, either the transverse or the oblique.

II. Cross-sections of the pelvis at right angles to the axis of the canal and in one of the recognized planes of the pelvis: (1) in a horizontal plane passing either through the conjugate of the brim, or (2) at a slightly lower level through the transverse diameter (for, owing to the high position of the promontory, the conjugate is above the transverse diameter); (3) in a plane passing through the lower edge of the symphysis and parallel to (1); (4) in the conjugate of the cavity; (5), in the conjugate of the outlet.

With these indications of the scope of sectional anatomy, the author draws attention more specifically to certain questions which these sections raise, though he does not consider that they have as yet answered them:

1. What are we to take as the starting-point in the mechanism of labor; at what point in the bony pelvis does the mechanism of labor begin?

2. How is the form of the bony pelvis modified by the soft parts?

3. What is the form of the fœtal head?

4. What are the movements of the mechanism of labor?

The author is satisfied that the *mechanism of labor begins* with the head in the cavity of the pelvis. The *different degrees of shortening of the diameter* of the bony pelvis by the soft parts, are: (at the brim) conjugate by .2 in., transverse by a reducible 1 in., obliques by .25 in. at their anterior ends; (in the cavity) conjugate by .4 in., transverse by 1 in., obliques by .75 in. *plus* a reducible .5 in. For the *form of the fœtal head* there were data from one section only. One of the sections almost bisected the head antero-posteriorly. The measurements here are: Sub-occipito-bregmatic diameter, 4½ in.; occipito-frontal diameter, 4¾ in.; occipito-mental diameter, 5 in. These figures included the soft parts covering the skull, and are of the unmoulded head before labor. Of the *movements of the mechanism of labor*, flexion, internal rotation, extension, and external rotation, the first two only take place in the pelvis.

Sectional anatomy catches the head "in the act." Sections from before labor and from the second stage are compared. The author draws attention to the following points: That the usual attitude of the fœtus in utero is one of flexion. It grows flexed. On comparing the frozen section of the child before and during labor, it was seen that if any change had taken place it was rather an undoing than an increase of the normal attitude. The sections already made go to prove that flexion belongs to the growth of the fœtus rather than to the mechanism of labor. The elongation of the fœtal ovoid with the compression of the limbs, during the second stage, is also noted; and the fact that, during a pain, its long axis is thrown forward into the axis of the pelvis inlet is of significance with regard to its being made to enter the pelvis with a minimum of resistance.—*Edin. Med. Jour.*, July, 1889.

Ferguson (J. Haig) on a Variety of Post-partum Shock: its Nature, Cause, and Prevention.—Three cases of post-partum shock form the subject of this paper. The patients were all young, healthy women of decidedly nervous temperaments, two of them primiparæ and one a iv.-para. There was nothing specially remarkable about the first or second stage of labor in any of them, ex-

cept that two were low forceps cases, and two of them had chloroform administered towards the end of the second stage. Forceps were applied to prevent exhaustion and for fear of impending inertia. None of the patients lost more than about twelve ounces of blood in the third stage, their uteri contracted firmly and well, and in no sense of the word did they suffer from post-partum hemorrhage, concealed or otherwise. Eclampsia and cardiac disease could be clearly eliminated in all of them. Yet they all manifested decided symptoms of syncope and shock, became perfectly unconscious, with feeble, rapid, irregular, sometimes imperceptible radial pulse, dilated pupils, shallow irregular breathing, and cold, clammy perspiration. The face, at first anxious, soon developed a vacant, torpid expression, and sensibility to pain absolutely and entirely disappeared. This state continued for three hours — fully longer in one of the cases,—and there was, of course, complete inability to swallow. Free injections of stimulants, sinapisms to præcordia, and hot bottles, hot blankets, and gentle massage gradually brought them back to life. In from eight to twelve hours, they had, to all appearance, quite recovered from the effects of the shock, and beyond a feeling of exhaustion, and some degree of tenderness in the lower part of the abdomen, nothing unusual was to be remarked. Memory was a complete blank during the greater part of the attacks. Nothing unusual had occurred in the first or second stage in any of the cases, hence it was to the third stage that the author turned for an explanation of the phenomena.

All the patients complained of unusual tenderness when the uterus was grasped by the hand in the usual way, through the abdominal wall, after the expulsion of the child; and when the uterus was compressed more forcibly, according to Crédé's method, in order to squeeze out the separated placenta, the pain became so intolerable as to completely awaken them from their partial anæsthesia, and they shrieked in agony, declaring it to be worse than the whole labor put together. In one of the cases the uterus was somewhat soft and flabby, and it had to be kneaded pretty energetically before it contracted satisfactorily. There was, however, no hemorrhage to speak of. The shock in each case occurred either during or immediately after the expulsion of the placenta from the vagina, and when the uterus was being firmly grasped through the abdominal wall. The writer feels no doubt that the cause of the symptoms was the fact that one or both ovaries were being squeezed and bruised by the pressure of the external hand compressing one or both against the hard contracted uterus. This accounts equally for the exquisite pain from which the patients suffered when the uterus was being compressed, and for the syncope which supervened on the intense shock thus produced. If a patient should complain of some pain during the manipulation of the post-partum uterus, the author thinks that there should always be feared that the ovaries are being compressed at the same time. He considers that if the accoucheur will be careful to grasp the uterus antero-posteriorly, as regards itself, the ovaries will be free from danger.—*Edinburgh Med. Jour.*, July, 1889.

[Rem. In these cases, it must be noted that the lateral (English) obstetric position was used. This brought the hand of the accoucheur, on whichever side he stood, over the fundus laterally or obliquely and made it almost impossible to grasp the uterus antero-posteriorly. In this country, where the French position is so largely preferred, it appears to me doubtful if such accidents as above described often would occur. I have expressed the placenta in several hundred cases in hospital and private practice, and have often heard the patient complain of the soreness of the fundus, but I have never seen shock, which could not be satisfactorily explained on more probable grounds, follow. I think it extremely unlikely that the ovaries would be injured by expressing the placenta if the patient was in the dorsal decubitus.—E. S. B.]

Spencer (Herbert) on the Diagnosis of Placenta Prævia by Palpation of the Abdomen.—At a recent meeting of the Obstetrical Society of London, Dr. Herbert Spencer, Assistant Obstetric Physician to University College Hospital, described a method of abdominal palpation of the pregnant uterus by which he had many times made a correct diagnosis of placenta prævia. Two cases are briefly described in illustration of the possibility of determining the site of the placenta by abdominal palpation when it is situated in the upper segment of the uterus. The

author then gives in detail seven cases of placenta prævia (all the cases he had investigated from this point of view), in which he had been able by palpation of the abdomen to diagnose the presence of the placenta in the front wall of the lower segment, or assure himself of its absence from it, before a vaginal examination was undertaken; and when the diagnosis was subsequently verified by vaginal and intra-uterine examination. The seven observations were all made in multiparæ with head presentation, before the membranes were ruptured, without the employment of an anæsthetic, and in the absence of pain. In three of the seven cases the exact site of the placenta on the front wall of the lower segment was determined by abdominal palpation, and in two of these the placenta was felt at a time when it was impossible to feel it by the vagina. In the remaining four cases the placenta was diagnosed by abdominal palpation to be absent from the front wall. In making the examination, it was necessary that the patient should lie on her back, the bladder having previously been emptied. The examination should be gentle, made in the absence of pains, and prolonged over several minutes, or repeated if necessary. The following rules for making the examination are formulated: In an ordinary vertex presentation (placenta in the upper segment), the occiput, forehead (at a higher level), and side of the head could, under favorable circumstances, be distinctly felt in the lower segment of the uterus by means of abdominal palpation. In a case of placenta prævia in which the head presented, the head was not felt where the placenta was situated; it was distinctly felt when the placenta was absent. In cases where the placenta was in front the organ was felt as an elastic mass of the consistence of a wetted bath-sponge, which kept the examining fingers off the head. Its edge might be felt and had the shape of the segment of a circle; within the circle all was obscure to the touch; outside the circle the head or other part of the child was plainly felt. Impulses to the head were not clearly felt through the placenta; impulses to the head through the placenta were distinctly felt at the spot from which the placenta was absent. The same applied to combined vaginal and abdominal examination.—*Br. Med. Jour.*, June 15, 1889.

OCCASIONAL REPORT ON DERMATOLOGY.

BY CONDICT W. CUTLER, M.D.

Lassar. Hair Receipt for Alopecia.—Lassar holds that many cases of alopecia are parasitic in origin, and has used the following method of treatment for its relief with great success:

Wash the scalp thoroughly with tar soap each day, wash out the suds, dry thoroughly, and anoint with

℞.—Hydrarg. bichlor. 6
Glycerin. 100.0
Cologne water 100.0

Rub dry with absolute alcohol containing ½ per cent. of naphthol, and then anoint with

℞.—Salicylic acid . . . . 3 ss.
Tinc. benzoin . . . . gr. xiv.
Neats-foot oil . . . . ℥ iii.

After six or eight weeks the process does not need to be repeated so often. —*Therap. Monatshft.*, Dec., 1888.

Jackson (J. T.). Treatment of Zoster.—Unna recommends painting the affected parts with ichthyol or equal parts of zinc paste with resorcin which will often absorb the vesicles. Another method is to cover the spot with wadding soaked in a ten per cent. solution of resorcin or ichthyol and cover this with muslin adhesive plaster, leaving it on for several days.

To prevent the vesicles from becoming purulent, apply zinc-sulphur paste or alcoholic solutions of corros. sublimate, iodoform, carbolic acid, or resorcin.—*New York Med. Jour.*, August 17, 1889.

Jackson (G. T.). Exfoliatio Areata Linguæ.—This disease has been known by many names, but this name has been given to it by Unna, and generally adopted. The disease is very manifold in its appearance, but Unna gives the symptomatology as follows:

Upon an otherwise perfectly healthy tongue there will appear red spots with smooth surfaces from which the upper layers of epithelium have evidently fallen. Around them will be a whitish ring which is more or less raised. These spots are continually changing their location in a most capricious manner from day to day, and even from hour to hour, and their appearance and exfoliation take place very rapidly. So they come and go, returning

again and again to places previously affected which have healed. There are no subjective phenomena, and the course of the disease is benign but most chronic. Its superficiality, its seat upon the tongue exclusively, the entire absence of ulceration and infiltration—these will suffice to distinguish it from aphthæ and from catarrhal ulceration. Leucoplakia buccalis differs from exfoliatio areata linguæ in the lesion being stationary. Syphilis of the tongue might offer some difficulty in diagnosis to a superficial observer. But the erosions of the tongue in early syphilis are more profound, often dry, sharply limited, fixed in their seat, and not surrounded by a raised whitish margin. In syphilis there is also an inflammatory tumefaction of the connective tissue of the filiform papillæ. In the exanthems, and in recovery from grave illnesses, transient exfoliation of the tongue takes place. But these exfoliations do not assume the typical "area" form, and disappear completely with the recovery from the disease with which they occur. Should the exfoliation continue for some time after recovery from the constitutional disease, the lesion will be single and of irregular, indefinite shape, will occupy a large part of the surface of the tongue, and will not migrate from place to place. The ætiology of the disease is obscure. Some have endeavored to establish a connection between it and menstruation, anæmia, dentition, and catarrhal conditions, but, with the exception of the first of these, the author has been unable to establish any such relation. It has no relation to syphilis. No treatment is necessary.—*New York Med. Jour.*, August 3, 1889.

Stern on Lanolin Ointments.—(1.) *Taplanolin*, a mixture of 2 parts of green soap and 2½ lanolin, with which all ordinary medicaments may be added excepting salicylic acid. This is especially serviceable in parasitic disease, infantile eczema, and with white precipitate ointment in psoriasis capitis.

(2.) *Lanolin Wax-paste*, a mixture of 40 parts each of yellow wax and lanolin, and 20 parts olive oil melted together. It is very useful for adhesive dressings and all kinds of medicaments may be incorporated with it. With zinc oxide and salicylic acid it is very serviceable in squamous eczema.

(3.) *Fluid Lanolin Injection*, a mixture of lanolin 25 parts, almond oil 75 parts, to which may be added zinc sulphate, etc.—*Therap. Monatshft.*, February, 1889.

Unna on Treatment of Squamous Eczema of the Back of the Hand.—This disease is probably always a seborrhœal form of eczema and usually associated with seborrhœal affections in other regions. The treatment consists in covering the affected part with cotton batting soaked in the following solution:

Resorcin	10 parts
Glycerin.	10 "
Dilute alcohol . . .	180 "
Water	180 "

This is to be applied in the evening and covered with rubber tissue to keep the cotton moist. During the day zinc ointment with tar or resorcin should be applied once or twice.—*Monatshft. Derm.*, 1889, No. 4.

Jamison (A.) on Treatment of Hypertrichosis.—When there are large surfaces covered with hair the use of sodium ethylate yields far better result than any other agent in permanently removing all the hairs. As its application is accompanied with a good deal of pain, it is better, especially with children, to use an anæsthetic. The ethylate should be rubbed over the surface freely after the hair has been cut short, until the skin has an orange appearance. A little cold cream should then be applied. This form of treatment is especially applicable in the cure of hairy moles, for it not only removes the hair but also the discoloration of the skin.—*The Practitioner*, July, 1889.

Macintosh (D.) on Internal Treatment of Acute Eczema.—The first essential in the treatment of eczema is that the bowels should be kept well open. In children gray powdered rhubarb and bicarbonate of soda, a grain each, taken every second or third night, will answer every purpose. In adults sulphate of magnesium is far the best purgative medicine in eczema, and should be taken an hour before breakfast, or in smaller doses an hour before each meal. It is often well to begin your treatment with a blue pill taken at night, and followed in the morning with the magnesia. Iodide of potash acts well only in those eczematous cases occurring in gouty or rheumatic patients, and arsenic never in the acute stages.—*The Practitioner*, July, 1889.

Jackson (G. T.) on Canities.—*Congenital* canities usually occurs in the form

of tufts or patches of more or less pure white hair showing conspicuously amongst the normal growth. When the whiteness is general we have albinism, which is associated with a deficiency of pigment in the whole body.

Acquired canities may be premature or senile. It is premature if it occurs before the age of thirty-five. The hair about the temples usually turns white first, then spreads over the head, afterward affects the beard, and lastly the hair of the axilla and pubis. If the grayness of the hair is due to some passing cause, as fear, anxiety, or disease, it is possible for it to fall out and reappear again in its normal color; but when due to senile changes it is always progressive and permanently gray. Senile canities is usually followed by alopecia in from one to five years, and is more common in males than females. The hair turns gray first at its root, the whiteness being due to the absence of color. The darker the hair originally the more apt it is to turn gray. Sudden whiteness of the hair as in cases of great fright, is very rare, and is due to a bleaching of the pigment rather than to its absence; or else dependent upon the formation of air bubbles between the hair cells of the cortex, thus rendering it opaque so that the color of the pigment in the medulla is obscured. If these air bubbles are driven out by placing the hair in hot water, turpentine, or ether, the normal color of the hair will return.

Among the most common exciting causes of gray hair are heredity, sudden fear, neuralgia, dyspepsia, chronic diseases as syphilis and tuberculosis and frequent hemorrhages.

Although we cannot restore gray hair to its normal color except by the use of hair dyes, we may frequently check the process by removing the cause.

Leonard gives the following safe preparations for dying the hair black:

No. 1.

℞.—Bismuthi citratis . . . . . ℥ i. = 32.
Aquæ rosæ,
Aquæ destillat. . . . . āā ℥ ij. = 64.
Alcoholis . . . . . ʒ v. = 20.
Ammoniæ . . . . . q. s. = q. s.

SIG.—Apply in the morning.

No. 2.

℞.—Sodii hyposulphit. . . ʒ xij. = 48. (60.)
Aquæ destil. . . . . ℥ iv. = 128. (140.)

SIG.—Apply in the evening thoroughly to the hair.

—*Journal of Cutaneous and Venereal Diseases*, vol. iii., No. 2.

Anderson (T. McCall) on Xeroderma Pigmentosum. — The disease usually presents the following clinical history: Freckles make their appearance at first only during the hot season, disappearing in winter but returning each summer with increased intensity, and at last becoming permanent and growing almost black in color. After a time new features make their appearance, namely: 1, little reddish vascular spots; 2, cicatricial spots, surrounded by vascular areas, and 3, little warty nodules. The whole surface of the body may become thus affected, but the face, neck, hands and arms is the order in which the disease spreads, and it may remain limited to these regions. The individual lesions are quite small, but may unite and form large and irregular patches. In the last stage of the disease, which may not appear for many years, the warty growths may become epitheliomatous in character, fungoid growths develop, and the vascular or pigmentary spots become warty and ulcerate, and terminate the life of the patient.—*British Med. Journal*, June 8, 1889.

Dumesnil (H. H. O.) on Alopecia Areata Due to Traumatism.— The case was that of a young man who almost a year previously met with a scalp wound. This kindly healed, but about a month later the hair began to fall out in spots, posteriorly to the seat of injury, until at the end of a year the alopecia areata is well advanced.

Todd, Anderson, Kaposi, and others have recorded cases of alopecia areata due to the same cause, and consider them as neurotic, and thus but indirectly produced by the injury.—*Weekly Med. Review*, June 29, 1889.

Dalton (H. C.) on Xerostomia.— Under the name of xerostomia or dry mouth, Dr. Hadden gives a brief account of an affection which has been described by himself and by Mr. Hutchinson at the Clinical Society. All the subjects were women, mostly between the ages of 50 and 65. The disease began suddenly in these cases, preceded in two by a severe mental shock. In all the cases the condition of the mouth was the same. The tongue was red, devoid of epithelium, cracked, and absolutely dry, its appearance being like that of raw beef. The inside of the cheeks, the hard and soft palates, were also dry; the mucous membrane soft, shiny,

and pale. The salivary glands appeared normal, and no mechanical obstruction was detected in their ducts. The general health remained unimpaired, and in spite of the absence of saliva no digestive disturbance resulted. Articulation is difficult in consequence of the absence of moisture, and swallowing has been assisted by constant sipping.—*The Medical Standard*, July, 1889.

Dalton (H. C.) on Campho-Phenique in Anthrax.—Campho-phenique is one of the most excellent antiseptics and germicide remedies. It is especially serviceable in anthrax, for it acts as an analgesic as well as antiseptic. It may be used as follows:

After anæsthetizing, a crucial incision is made, carrying the knife well down to the healthy tissue and dissecting up the flaps. With scissors and sharp curette remove as much as possible of the necrotic tissue, under constant irrigation of a 1–2,000 bichloride solution. Then pack the wound full of absorbent cotton saturated with campho-phenique.—*The Medical Standard*, July, 1889.

Harris (J. B.) Rejuvenescence of the Hair.—The patient was a man sixty-five years old and bald for many years. An explosion of gas severely burned and blistered his bald head. As the burns began to heal, hair of a dark-brown color commenced to grow, until at the end of six months he had a new head of hair, thick and strong,—nearly as much as he had ever possessed.—*The Lancet*, July 27, 1889.

MEDICINE AND PATHOLOGY.

Is Muriatic Acid a Safe Remedy for Dyspepsia when there is Renal Disease?—Dr. H. Girard, of Geneva, publishes a case of dyspepsia in a patient aged forty, subject to chronic catarrhal nephritis, in whom the use of a 0.3-per-cent. solution of hydrochloric acid (one tumblerful during meals) caused marked exacerbation of the renal affection, with hæmaturia, lumbar pain, etc., the symptoms developing on the third day of the treatment. Another Geneva practitioner, Dr. Paul Demièville, similarly saw a dyspeptic patient with chronic Bright's disease, in whom five-drop doses of dilute hydrochloric acid (with water, after meals) was almost immediately followed by hæmaturia and other symptoms distinctly pointing to a serious aggravation of the renal disease. In both these cases the patients speedily improved under milk diet with ordinary soothing remedies. In view of these cases, Dr. Demièville states that hydrochloric acid, even in ordinary medicinal doses, has an injurious effect on the diseased renal epithelium; hence it should not be given in chronic nephritis, or in those acute infectious fevers (scarlatina, enteric fever, etc.), in which kidney complications are apt to occur. On the other hand, Professor Bourget, of Geneva, relates a case which does not seem to confirm the apprehensions of Drs. Girard and Demièville. A man, aged twenty-eight, attempted his life by swallowing 100 cubic centimetres of commercial concentrated muriatic acid. Several hours later he was brought to Professor Revilliod's clinic, where the urine and vomited matters were chemically analyzed day by day. Exactly three months after the ingestion of the poison, the patient died from cachexia, due to stenosis of the pyloric orifice. The kidneys were found to be quite healthy. During life analysis had failed to detect any trace of free muriatic acid, or of an increase in chlorides, in his urine. On the contrary, the proportion of chlorides in the urine was distinctly subnormal, while the vomited matter contained as much as 10 per mille of chloride of sodium. Hence, Dr. Bourget concludes that: (1) in case of poisoning, HCl is not eliminated by the kidney; (2) therefore no trace of free acid is found in the urine; (3) as the kidneys remain intact even on the ingestion of 100 cubic centimetres (or even 200, as in Letulle and Vaquez's case) of a concentrated acid, it may, *a fortiori*, be concluded that a diluted HCl, administered in therapeutic doses, cannot cause lesions in the kidney.—*Brit. Med. Jour.*, June 22, 1889.

Stewart (D. D.) on Cocillana in Diseases of the Lungs.—Cocillana is the bark of a tree—a species of Guarea, of the family Meliaceæ. Like its near relative, the Goanese Ipecac, or Naregamia alata, of India, it is used at the place of growth as an emetic and purgative (very rarely the latter), and is poisonous as an irritant-narcotic in over-doses. It contains apparently an alkaloid. It acts locally upon the mucous membrane either when directly

applied or when absorbed; in the latter case it is quickly excreted through the mucous membrane, the upper portions of which are successively more active in the elimination. It is excreted very slightly through the skin.

From experiments by the author, it appears that cocillana is serviceable in bronchial catarrh, especially the subacute and chronic forms, when accompanied by scanty or moderately profuse secretion, whether the cough be tight or loose. It seems to possess the power to render cough less frequent and difficult, and the bronchial secretion less viscid and more easily expectorated, while at the same time it diminishes it in amount.

Perhaps the best preparation of cocillana for administration is the fluid extract, because of the relative smallness of the dose: seven and one half minims of it equal about half a fluid drachm of the concentrated tincture. The fluid extract is to be preferred to the tincture in cases of acute bronchitis, since the amount of alcohol contained in the latter is apt to aggravate the inflammatory condition. In cases of chronic bronchitis, broncho-pneumonitis, and the bronchitis intercurrent with phthisis, the tincture is not open to this objection. The average dose of the concentrated tincture is about three fourths to one fluid drachm.—*Med. News*, Aug. 24, 1889.

Typhoid Fever in Dogs.—Dr. J. R. Roberts, of the Indian Medical Service, has published an interesting note on the occurrence in dogs of lesions resembling those of enteric fever in the human subject. While stationed at Sialkot during the last cold weather, he was led, by the occurrence of a heavy mortality among dogs of European breeds, to make a series of post-mortem examinations. In a certain proportion of cases he found the following coincident lesions: (1) An enlarged, dark-colored, friable spleen; (2) swollen, inflamed mesenteric glands; (3) large oval ulcers in the ileum; (4) swollen oval patches; (5) points of submucous hemorrhages; (6) large intestine, with submucous hemorrhages along the crests of the longitudinal rugæ seen in the dog; (7) inflamed vermiform appendix. The animals presenting these lesions had suffered during their illness from continued indisposition, increasing debility, distaste for food, vomiting, and stools, which, if passed by a human patient, would be at once pronounced typhoid, though this was by no means invariable, as constipation might be present. The temperature might be high—in one case it was 104.5°,—but temperature in dogs, though normally about 100°, can easily be raised to 163° or higher by exercise. About four years ago Mr. Bland Sutton communicated to the Pathological Society of London a paper on the occurrence of a disease in monkeys and in beavers, which he identified with the typhoid fever of man; he also observed the lesions in a tiger in a solitary case. The only symptoms observed during life were diarrhœa and hemorrhage, but it was not possible to make careful clinical observations. He pointed out that M. Serres had recorded the occurrence of typhoid fever in monkeys, dogs, and cats, and had made some extended observations during an epidemic which occurred among the monkeys in the Musée d'Histoire Naturelle, in Paris; the symptoms observed were diarrhœa, increased frequency of pulse, and fever, ending almost always in death. Dr. Roberts suggests that if further examination should prove that dogs, as he suspects, are liable to typhoid fever, that fact would help to explain the continued prevalence of the disease in Indian cantonments, in spite of the sanitary precautions taken.—*Brit. Med. Jour.*, Aug 3, 1889.

Thistle (W. G.) on Typhoid Fever in Domestic Animals.—Your article on the above subject reminds me of the prevalence of typhoid amongst oxen and dogs in Nathal in 1880. Dr. Saunders, A.M.D., and myself found the typical lesions of typhoid in several cases we examined of these animals that had died with all the symptoms of the disease. Moreover, he has pointed out that, in fresh encampments there during 1879 and 1880, the cattle were first attacked with diarrhœa, hemorrhage, "redwater," "lung sickness," and that after a few weeks the men were down with genuine typhoid, suggesting a progressive development of the virus.—*Brit. Med. Jour.*, Aug. 10, 1889.

Firth (R. H.) on the Kola Nut.—The observations on which the report is based were made on English soldiers at the Main Mir Camp of Exercise during Jan., 1889. The kola nut is largely used in the interior of northern Africa as a stimu-

[1] *Indian Medical Gazette*, June, 1889.

lant, and has been found to have the following percentage composition: Caffeine 2.4, theobromine 0.02, water 11.9, proteids 6.7, starch 33.7, sugar 2.8, fats 0.68, tannin 1.6, coloring matter 3.7, cellulose 30, ash 6.5. As the result of a series of observations, Surgeon Firth has come to the following conclusions: 1. That kola nut is in no sense a food. 2. That in man it increases the total urinary water, with a slight reduction of its total solids, and a marked reduction of the extractives eliminated by the urine. Such action is probably due to its contained caffeine. It in no way affects the nitrogen output of the body. 3. That there is a stimulant action on the nervous system, the heart-beat is temporarily strengthened, and the arterial tension increased. Taken continuously during times of exertion and fasting, it possesses some power of warding off the sense of mental or physical depression or exhaustion, this power not being, however, so marked as some observers have reported. 4. That it might be employed on service as an issue to troops in the form of broken up nuts, the same being issued with instructions that a piece be constantly kept in the mouth and chewed, and the saliva swallowed. 5. That as an infusion with milk and sugar, kola powder is an efficient substitute for tea or coffee, especially for those suffering from diarrhœa, owing to its astringency. 6. That as a therapeutic agent in the convalescence from long sickness, its value is not apparent. 7. That its alleged antagonistic action to alcoholic sequelæ is not capable of proof. 8. That as a purifier of water its action is purely mechanical, and not superior to many mucilaginous seeds. 9. That seeds from species of sterculia which contain no caffeine must be carefully excluded. 10. That continued mastication of the solid nut is the best way to take it.—*Brit. Med. Jour.*, July 27, 1889.

Jamison (A.) on Some Uses of Sodium Ethylate.—Miss P., aged twenty-five, had a hairy mole, about the size of a six-penny piece, growing near the angle of the jaw on the right side of the cheek. This mole was peculiarly unsightly. Long coarse hairs grew from it, and the skin on which they were seated was of a dirty blackish-brown color, and very rough in texture. The hairs were generally kept closely cut, and the mole dusted with cosmetic powder. Not improbably excision would have been good treatment in this case, but the young lady did not desire it. I cut the hairs as close to the mole as I could with a very fine pair of scissors, and then painted it over with sodium ethylate, using a fine glass rod to do so. When the mole had a varnished look from the application, I gently rubbed the ethylate in with the glass rod to make it penetrate more deeply into the hair follicles. I was very careful not to let any of it run off the mole on to the sound skin of the face. The mole had quite a black look when the little operation was over; a hard crust formed over it, which was nearly three weeks in becoming detached. When it came off the hairs were seen to be destroyed, and the surface of the mole to have a smooth somewhat cicatricial appearance, of a much lighter color than before. This has become much smaller in size and much less noticeable in appearance, though there is still a slight mark, now less than a three-penny piece in size, and hardly perceptible. The patient tells me that I see the mark more than any one else, because I am always wanting to observe the result.

I may mention also that in those vascular areas seen on the sides of the nose in children, formed by vessels radiating from a common centre, a very small drop of the ethylate applied with a fine glass point to the very middle of the vascular area destroys or obliterates the vessels below, and then those radiating from it disappear, and no mark at all is left.—*Practitioner*, Aug., 1889.

Loomis (H. P.) on Multiple Ulcers of the Stomach in a Morphine Habituée.—The specimen was removed from a woman, forty-two years of age, a nurse by occupation, who was admitted to Bellevue Hospital the 29th of March. Her parents died of old age. She denied alcoholic habits and a specific history. The patient was strong and well, up to twelve years ago, when she had to have her foot amputated, and as a result of attempts to relieve a severe neuralgia in the stump, she became addicted to the use of morphine. Since this time she had never been well, and had always taken morphine to excess. For the last three months she had been troubled with incessant vomiting and a severe pain in the epigastric region, and had been growing weaker and weaker.

On admission to the hospital the patient was vomiting almost constantly; the mate-

rial consisted of partially digested food. mucus, and, once or twice, some black coffee-ground material. A microscopical examination of the urine showed it to be normal. After a few days, by keeping the patient on a peptonized milk diet, giving oxalate of cerium and morphine, the vomiting stopped, the pain over the stomach improved, and the patient seemed to be doing so well that the visiting physician, after careful examination, directed that she be transferred to Charity Hospital. While sitting in the ward, waiting to leave the hospital, the patient fell over and died almost immediately.

Autopsy, eight hours after death.—Lungs: the right lung was normal, with the exception of some old adhesions at the apex. The lower lobe of the left lung was bound completely to the chest-wall by new connective-tissue bands, and was almost airless; the upper lobe was normal. The heart-walls and cavities presented a normal appearance; there was some thickening at the base of the aortic and mitral valves, and the aorta was atheromatous. The spleen was enlarged and soft. The liver was of normal size, and showed the ordinary appearances of fatty infiltration. The kidneys were intensely congested; otherwise a normal appearance. The brain showed a slight opacity along the vessels of the convexity, which were intensely congested. Stomach: The organ was of normal size and empty. On opening the stomach, the mucous membrane was seen to be intensely congested, and the surface presented the ordinary appearance of a chronic catarrhal inflammation at the pyloric extremity. On the posterior surface, and near the lesser curvature, were four ulcers, the largest a half inch in diameter, the smallest the size of a pea. They were of circular shape, with "clean-cut" edges; their floor showed no active inflammatory changes. One of the ulcers had penetrated as far as the muscular coat, another to the peritoneum, which could be seen as a thin membrane by holding the stomach up to the light. The largest ulcer had perforated, and looked like a clean hole punched out of the wall of the stomach, the edges of which were rounded and smooth. There was no evidence of peritonitis. The intestines were very anæmic and small, but no lesion was found in them.—*Med. Record*, Aug. 24, 1889.

Mallet, on Spontaneous Rupture of the Heart.—The patient was a man aged 79, with pulmonary disease. He died suddenly after rising to micturate. A rent, almost vertical and over two inches long, was discovered in the anterior aspect of the wall of the left ventricle. The pericardium was full of blood, the aorta atheromatous, and the left coronary artery nearly obliterated. All the valves were normal. Dr. Mallet quotes Odriozola's statistics of spontaneous rupture of the heart. That observer could only collect 176 authentic cases. In many instances the patient was old, being between 60 and 70 in thirty-six, and between 70 and 80 in forty-five. The accident appears most frequent in women. As a rule, the escape of blood into the pericardium is considerable. The rent in the wall was unusually large in Dr. Mallet's case. In nearly every instance in Odriozola's statistics, the rupture was in the anterior part of the left ventricle. The original report of the case deserves study. The rupture apparently took place fifty-three hours before death, when the patient was seized with dyspnœa and epileptiform convulsions marked in the upper extremities; his face turned pale. The exertion of rising to micturate caused immediate death, probably by sudden escape of blood into the pericardium. A similar history has been recorded in other cases of spontaneous rupture of the heart. —*Brit. Med. Jour.*, July 27, 1889.

Petitt (R. R.) on Death From Sulphonal.—Miss B——, aged twenty, American, dressmaker, was thrown from a carriage two years ago. Since then she suffered constantly from irritation of the spine and the symptoms of neurasthenia became marked, but she continued to use the sewing-machine as much as her strength would permit. There was no evidence of organic lesion. Neither rest, tonics, nor any form of local treatment caused improvement. She was always very nervous and now had almost constant headache. The excitement of a slander suit decided against her friends caused her to become entirely insane. The type was melancholia, but for a few days hysterical symptoms predominated. The first night she obtained several hours sleep by means of chloral, but her condition was such the next day that I thought the chloral did more harm than the sleep did good, so for several day I simply gave her frequent

small doses of cannabis Indica and potassium bromide, pushing her food as much as possible. Some nights she obtained no sleep and sometimes considerable. I then gave her xl ♏ of paraldehyde with no effect at all. Next day she received no medicine and at night I gave her fifteen grains of sulphonal and in one and a quarter hours, patient being still wild and wakeful, she was given fifteen grains more. She soon went to sleep and slept quietly till I saw her twelve hours later. She was then sleeping naturally, and for the next twelve hours she could be easily roused enough to swallow and by energetic stimulation enough to talk rationally, but when let alone would at once be asleep. Pulse 95, respiration but slightly accelerated, pupils normal.

About eighteen hours after taking the sulphonal, the pupils being contracted, $\frac{1}{100}$ grain of atropine was injected hypodermatically and from this on till near her death the pupils were neither unduly contracted nor dilated and responded to light. Aside from the atropine no remedy seemed to have any effect, though in all about $\frac{1}{12}$ of a grain of strychnine was injected, the faradic current, aromatic spirits of ammonia, and later whiskey were freely used.

Her temperature taken about the eighteenth hour was 102°. Leaving her about the twenty-second hour able to answer and strike those who were keeping her awake, I found her on my return an hour afterward apparently dying, greatly cyanosed and scarcely breathing. In trying to keep her up, her head had been allowed to fall forward; I made a complete extension of the head and she began at once to breathe freely. After failure of respiration began, her pulse being good, artificial respiration was kept up for several hours, but finally the cyanosis began to increase, and she died of failure of respiration forty hours after taking the sulphonal.—*Med. News*, Aug. 10, 1889.

Porritt (N.) on a Method of Treating Pruritus and Irritable Skin.—Pruritus, whether occurring as an accompaniment of some other affection, or manifesting itself as a symptom without tangible cause, not infrequently taxes all a practitioner's resources for its relief.

In three cases lately under my care, I have used, with good results, a cone composed of cacao butter impregnated with 2 per cent. of cocaine. This is rubbed over the part affected. The warmth of the skin melts off a layer of the cacao butter, which forms a soothing emollient shield over the irritable patch.

The remedy has been put up in the form of cones, enclosed in boxwood cases with screw-tops, something after the manner of menthol cones. These can be carried about by the patient, ready at any moment for self-application. The boxwood being a non-conductor of heat, prevents the heat of the body from melting the cone whilst it is carried in the patient's pocket.

In irritable affections of the skin, in cases of insect bite, in pruritus, and various forms of hyperæsthesia, the remedy is worthy of trial, and its use has distinct advantages over the more usual applications. Although containing cocaine, I regard the manner in which the cacao butter is spread out over the affected part as having a share in the curative process. It is a method of topical application capable of further development.—*Brit. Med. Jour.*, July 27, 1887.

Dodge (C. L.) on Convulsions Caused by an Overdose of Alcohol (Alcoholic Epilepsy).—On July 4, 1888, I was called to see a widow, thirty-four years of age. When I reached her house I found her on the floor struggling violently, and with difficulty restrained by her friends. The convulsions occurred every five or ten minutes, and were epileptiform in character. They lasted from 3 o'clock in the afternoon till after 6 o'clock. The paroxysms were very severe, requiring two or three persons to hold her and prevent her from injuring herself. The spasms were chiefly clonic, eyeballs rolled upwards, pupils dilated, face flushed, pulse rapid, and skin moist. Between the paroxysms she was almost maniacal; her expression was wild and excited, her eyes were injected, respiration frequent and irregular; she shouted and screamed at the top of her voice, tore her hair, struck her head on the floor, and strove in every way to free herself from restraint; she kicked, and tried to bite her friends, spat on them, and used coarse and vulgar language. These intervals would last from five to ten minutes, when she would be seized with another convulsion. There was no history of epilepsy in the family; she had never been attacked in this way before, and there seemed no assignable cause. I inquired if she had eaten an unusually hearty dinner, which was answered in the negative, and

could discover no cause for the attack. On coming near her I detected the odor of alcohol upon her breath, and immediately inquired if she was addicted to the use of it. Her sister told me that she rarely tasted liquor, but this day being the Fourth of July, they had some whiskey after dinner, and she took a very little with the rest. The odor upon her breath was so strong that I felt positive that she had taken more than her friends supposed. I then asked for the bottle, which had been removed from the table, and to the great surprise of all it was found to be empty. Her sister then said that there was all of a half pint of rye whiskey remaining in the bottle when they left the table, and no one had been down in the dining-room since but the patient, Mrs. D. It seemed quite clear to me now that an overdose of alcohol was the cause of the convulsions. About 6 o'clock the spasms ceased, but mental wandering and delirium lasted through the night. I gave her three compound cathartic pills about 6:30, and several doses of bromide of potash through the night. After the physic operated she slept some, and on awaking she seemed dazed and stupid for a time, but had no return of the convulsions.—*Med. Register*, Dec. 8, 1888.

Smith (R. P.) on Insanity Following Mumps.—Case 1. A clerk, aged nineteen, was admitted to Bethlem Hospital on June 19, 1888. He had enjoyed good health previously to this illness and had never suffered from insanity before, and there was no neurotic inheritance. A fortnight before admission he had suffered from mumps, there being other cases in the family and in the same village. His attack was associated with diarrhœa so severe as to be called "English cholera" by the doctor attending him. The patient was said to have been extremely exhausted and almost pulseless afterwards, and was described by his friends to have been "nearly gone." On recovering from this about five days before admission he became excited, sleepless, and rambling, and passed into a condition of acute mania, in which state he was admitted to hospital. There were no special features about his insanity while in the hospital; he rather rapidly improved, and was discharged recovered in October last.

Case 2. This case occurred in a young medical man who had an attack of mumps complicated with severe orchitis, for which he was admitted to a general hospital, and as a result of which he became depressed and suspicious, thought he was guilty of imaginary crimes for which he dreaded punishment, and was suicidally inclined. He had a short attack of melancholia, which passed off with improvement in his physical health, and eventually he recovered perfectly without the necessity of being sent to an asylum.

It is worthy of note that in both cases there was a severe complication associated with the mumps, so that there was considerable physical exhaustion, this seeming to have more to do with the attack of insanity than severe febrile process or metastasis.—*Lancet*, Aug. 10, 1889.

Walker (J. B.) on the Treatment Other than Climatic of Hemoptysis in Chronic Pulmonary Disease.—Hygienic measures are adequate for the arrest of most cases of hemoptysis occurring early in chronic pulmonary disease. They constitute much the most important part in the treatment of even grave cases. In ordinary cases, in addition thereto, sufficient doses of an opiate to quiet unnecessary cough will be all that is required.

For the severer attacks, or where their repetition gives only a slight hemorrhage a gravity it would not otherwise possess, we should administer either the peculiar hemostatics, turpentine, erigeron, tincture laricis, or others of this class; or astringents, preferably gallic acid or acetate of lead, and these preferably by the stomach.

If topical applications are resorted to, they should be such as admit of perfect solution in the atomized fluids, as alum; or in the air inhaled, as turpentine, and forced efforts at inspiration with the idea of carrying into the lungs a large quantity of medicated air to mingle with the complemental and residual volumes are to be guarded against, lest the very effort to increase their efficiency shall increase the hemorrhage.

Where the hemorrhage is serious from its excess or persistence, ergot should be frequently administered, by the stomach, if possible; hyperdermatically if rapidity of action is imperative.

But in most, if not in all cases, hemoptysis should be considered due to bacillary invasion, and efforts to lessen the vulnerability of the patient should be resorted to and followed persistently.—*Med. News*, Aug. 24, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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OCCASIONAL REPORT ON TOXICOLOGY.

Bage (C.) on a Case of Poisoning by Oxalic Acid.—A woman, aged about fifty, cleaner of straw hats, intemperate, was last seen alive at 8:45 A.M. on March 5th. She was then apparently in good health. On the same day, at about 6 P.M., she was found dead. She was lying on her side on the floor near her bed, dressed. Her body was cold and stiff. An empty cup, encrusted inside with crystals of oxalic acid, lay on the floor near her right hand. Oxalic acid, which is used in cleaning straw hats, was found in other parts of the house. Near her was a basin containing about two pints of yellow pultaceous vomited matter.

A post-mortem examination was made at 2 P.M. on March 6th. Body stout, and fairly muscular; cadaveric lividity well marked; no rigor mortis. The lateral ventricles of the brain each contained about half an ounce of clear fluid. The heart was soft, and contained dark fluid blood in all its cavities. The left ventricle was thin-walled and dilated. Both lungs were highly congested and softened. The liver was large and fatty; it was not congested. The spleen was small, dark, and soft. Both kidneys were small and granular, with adherent capsules. The bladder contained a few ounces of clear urine. The uterus and ovaries were normal. The mucous membrane of the tongue, interior of the mouth, pharynx, and æsophagus was pale and soft, but not swollen or abraded. The stomach contained a small quantity of undigested food, and its mucous membrane, as well as that of the lower part of the æsophagus, was thickly coated with greenish-black tenacious mucus. The membrane itself was pale and dark in patches, but not abraded, and the blood-vessels underneath it were distended with black blood. The intestines were normal.—*Australian Med. Jour.*, April 15, 1889.

Wingate (U. O. B.) on a Case of Poisoning by the Oil of Hedeoma (Pennyroyal).—At about noon, November 20, 1888, I was hastily summoned to see Mrs. ——, who, the messenger stated, was "in a fit."

I found a woman about twenty years of age lying on a lounge and wholly unconscious; pulse small; respiration very quiet; extremities cold; pupils moderately dilated; no froth in the mouth; could not be aroused. A neighbor present stated that the patient had experienced some domestic trouble that morning, and on hearing a noise she came in and found the patient on the floor, where she had apparently fallen from a chair. No one was in the room at the time she fell. This was all the history I was able to obtain, except that the patient was supposed to be about four months advanced in her first pregnancy.

I was at a loss to account for this condition, but suspecting hysterical causes on account of the history of domestic trouble, I applied digital pressure over the supra-orbital nerves. In about a minute convulsive movements of the face began, quickly followed by a general tremor over the entire body resembling a severe chill; then the body gradually and methodically as-

sumed the position of extreme opisthotonos, the patient resting entirely on the occiput and heels. The arms, hands, and fingers became strongly flexed, and the whole body was in a rigid tonic convulsion. In about a minute the muscles relaxed, the relaxation lasting about two minutes, when another convulsion of the same character came on. By this time I had administered gr. 1-4 morphia sulph. and gr. 1-120 atropia sulph. subcutaneously. The patient had no more convulsions, but soon vomited and began to answer questions. She then informed me that at 10 A.M. that morning she had taken a teaspoonful of the oil of pennyroyal and a half-teaspoonful of the fluid ext. ergot. at a single dose, with the object of procuring an abortion. She was put to bed, heaters applied, and given as much milk as she could be made to take. She talked incoherently for a few hours, complained of great lameness in the muscles of the neck and back, and also of the flexors of the arms. The next morning was sitting up; had some pain in the back, but no uterine action was provoked. Three months later I saw the patient, and she was well advanced in her pregnancy.

It may be of some practical importance to note the fact that toxic symptoms did not appear until about one and a half hours after the drug was taken.

This slow action is also true of other oils of this character, especially of the oil of tansy.—*Gaillard's Med. Jour.*, Aug., 1889.

Leidy (J., Jr.) on a Case of Petroleum-Ether Poisoning. — During the month of May, 1888, a strong, plethoric man, aged nineteen, weight one hundred and eighty pounds, a worker at Point Breeze Oil-Works, had been ordered to cleanse a large oil-tank, the substance used being petroleum-ether or benzine. He was found soon after lying upon the ground in an unconscious condition, in which state he was admitted. A new hand at the work, he had evidently used the substance in too large a quantity, for he was found soon after in the condition described, but, as his fellow-workmen thought, dead. Active means for resuscitation were resorted to, but with no avail. While a conveyance was being sought to remove him to his home, he was seen to move. In doubt as to his condition, they hurried him to the hospital, where I found him in the following condition: A man with a remarkably fine physique; unconscious, pulse strong and full, 60; respiration 14, very feeble, almost imperceptible; slight cyanosis; temperature 92.2° in the axilla; the body was cold; apparently but slight peripheral circulation in the extremities, arms, and legs, notably the nose and ears, which felt like ice; pupils widely dilated, and did not react to light; nystagmus, conjunctivæ barely sensitive to touch; paralysis, with incontinence of urine and fæces. The upper extremities resisted movements. Urine was tested and found normal, but with an ethereal odor. The driver of the patrol-wagon states he had a general convulsion (?) on his way to the hospital. Artificial respiration and friction, with mustard, of the body and extremities were immediately resorted to, and kept up for an hour, when we were rewarded by the patient taking several deep inspirations voluntarily. We persisted in this course until we had further evidence of return of consciousness. In an hour and a half from the time of his admission he opened his eyes and spoke, complaining of severe frontal headache. This gradually disappeared towards morning, when he was feeling so much better that he insisted upon leaving the hospital, which he did that day, feeling, as he stated, "as well as ever."

The treatment consisted in sustaining the respiration and heart by artificial respiration and frictions, with the internal administration of coffee.—*Therap. Gaz.*, July 15, 1889.

Prentiss (D. W.) on a Case of Poisoning by Japanese Lacquer.—Japanese lacquer is made from the sap of the *Rhus vernicifera*, a tree growing throughout Japan. Mr. H., in pursuance of his studies at the National Museum, in Washington, D. C., opened a bottle of lacquer which had been in the museum for years. There was a feeling as of a warm breath over the face, and a suffocating, disagreeable odor, which he could not liken to any known odor. It was neither musty nor pungent, but very unpleasant.

The irritation of the hands and face came on gradully for three days, when it was developed into a vesicular inflammation of the face, ears, neck, hands, and scrotum, having exactly the appearance of poisoning by *Rhus toxicodendron*. The eyes were nearly closed and the itching intense. He was suffering much and confined to the house.

He was ordered a liniment of

℞ Acidi carbolici, 1;
Ol. lini,
Aq. calcis, āā 50.

To apply constantly over the inflamed surfaces, and in addition a ten-per-cent. solution of carbolic acid to be applied over any intensely itching part.

He was sceptical of getting any relief, and had made up his mind to stand it until it ran its course.

When I called the next day he expressed himself as much delighted at the effect of the application, as it had almost entirely relieved the distress.

Subsequently the case ran the usual course of rhus-poisoning to recovery in ten days.

There was no irritation of the mucous membrane of the nose, mouth, or air-passages, as might have been expected from the inhalation of the poison.

The treatment here prescribed I have used in a number of cases of rhus-poisoning with the best results, more than once in my own person.

I always provide my family with a supply when they go to the country for the summer. It is useful not only for the purpose mentioned, but is also an excellent liniment for burns, erysipelas, bee-stings, and bites of insects.—*Therap. Gaz.*, July 15, 1889.

Prentiss (D. W.) on a Case of Poisoning by the Cashew-Nut.—Anacardium Occidentale.—In 1881, a gentleman connected with the United States National Museum, while organizing the materia medica collection, came across some nuts unlabelled. He sawed one of them through to make a specimen, and got some of the tar-like substance between the shell and kernel on his hands. A few days after, the face and hands became violently inflamed, a vesicular eruption accompanying the inflammation and intense itching. The face was of deep orange color; eyes closed by swelling. The inflammation extended to the edge of the hair, but not to the scalp.

He was confined to the house for a week, suffering most from the intolerable itching. In ten days he recovered, the skin desquamating from the parts affected.

The nuts were afterwards identified as "Cashew-nuts," from the *Anacardium occidentale.*

Treatment of the case not stated.

The affection corresponded exactly with rhus-poisoning.

There are two species of the Cashew-nut, —*Anacardium occidentale* and *A. orientale*, —natives of India and China. The fruit is edible. The nut grows in a curious way upon the outside of the fruit at its distal extremity, and is about the size of a small hickory-nut. Between the outer shell and kernel is a pulp containing a black, tarry juice, of an actively irritating nature. This juice makes an indelible stain upon fabrics, and the tree in consequence is popularly called the "marking-nut tree."

It is said to be used also by the natives as a vesicant, and applied to the floors to destroy or drive out ants.

Dr. Newton, in the Pharmacopœia of India, says the native women use the juice to produce abortion, applying it to the *os uteri.*—*Therap. Gaz.*, July 15, 1889.

Vaughan (A. E.) on Poisoning from an Excessive Dose of Sulphur.—J. S., mechanic, had suffered for some time from external piles. He applied to a chemist, who sold him one ounce of sublimed sulphur, with directions to take it overnight. This was on Monday; he took the dose, and repeated it on Tuesday. On Wednesday I was called in hurriedly, as the man was supposed to be dying. I found him lying on his back in bed, utterly prostrate and partially insensible. He had had repeated rigors during the day, and in lucid intervals complained of intense frontal and vertical headache, with aching griping pains in the bowels. His symptoms on examination were briefly: Temperature 104°; pulse hard and quick (120 per minute), tongue dry and deeply furred; breath fœtid, and smelling strongly of sulphuretted hydrogen; pupils strongly contracted and insensible to light; skin bathed in a profuse clammy perspiration; abdomen tympanitic and very tender on slight pressure. He retched and vomited almost continuously, and was several times purged during my stay—both vomit and dejecta being composed mainly of slightly bloody mucus mixed with fine particles of sulphur. The urine he had passed (in driblets) also contained blood. Having ascertained the cause of his illness, I had hot fomentations applied to the abdomen, and administered a moderately large dose of castor-oil. The next day he was still purged, but most of the irritant sulphur appeared to have been eliminated, so I considered it safe to treat the case as one of acute enteritis, and put him under a course

of opiates. He remained in bed for about a week, but otherwise has made an uninterrupted recovery. The case appears interesting, since sulphur is not usually counted as a poison, and to the best of my belief is not recorded as such. The dose taken (two ounces) was very large, and the symptoms produced were certainly those of a strongly irritant poison.—*Br. Med. Jour.*, Nov. 3, 1888.

Toxic Symptoms Produced by Glycerine.—Dr. Jaroschi recently reported to a Prague Medical Society a case which had come under his care of a man who, having been induced by something he had seen in a popular journal concerning the virtues of glycerine to take large quantities of it, soon became seriously ill. He suffered from vomiting, painful defecation, and pain in the calves of the legs. Under suitable treatment, the glycerine being of course interdicted, he was not long in recovering. The etiology of the case is not very clear, but it seems that the glycerine used was bought, not from a chemist's, but from an oil shop, as it was cheaper there, and it is said that the glycerine of commerce not unfrequently contains a very appreciable quantity of arsenic; at least Ritzert, who investigated the matter some time ago, reported that he had found "large quantities" of arsenic in commercial glycerine. As glycerine is now very frequently prescribed for rectal use, and as patients frequently purchase it at oil shops, it would appear to be important to get the question of its liability to contain arsenic settled, and if any uncertainty be found to exist, it would be well to caution patients to buy their glycerine at a chemist's.—*Lancet*, June 29, 1889.

Cluxton (F. C.) on Poisoning with Calla Lily.—On the 26th I was called at 3.30 P.M. to see the child of J. C., aged 32 months. The history of the case is as follows: Previous to 1 P.M., same day, the child was perfectly healthy. About that time the mother observed the child, walking along the sidewalk in front of the house, chewing the stem of a Calla lily, which one of the neighbors had thrown out. She took it away, and, after giving the child a piece of pie, put it to bed; the child slept until three o'clock, when it woke up with rigors, vomiting, paleness, and subsequently lividity of countenance, convulsive movements, and failure of the circulation. By active stimulation, digitalis, atropine, etc., it recovered. This was followed by high fever. The first evacuations of the bowels were normal but were followed by slimy, tarry evacuations, foul smelling. At this date child still very weak and in critical condition. On the 29th the hips and lower limbs were covered with a papular, dusky, and apparently hemorrhagic eruption. This was ascribed to contact with bowel discharges.—*Therap. Gazette*, June 15, 1889.

Putnam (J. J.) on Chronic Arsenical Poisoning.—A gentleman, about 60 years of age, has been under my care for a number of months. His symptoms consisted in profound and progressive anæmia, causing excessive pallor, puffiness of the face, œdema of the ankles, with great weakness, and perhaps causing also a loud and rough systolic murmur at the apex of the heart, with enlargement.

Not being satisfied with the diagnosis of an anæmia secondary to cardiac disease, and not wishing to adopt that of essential anæmia without eliminating other causes, I advised an analysis of the wall-papers, which had been put on twenty years before, by one of the best local dealers, who asserted that they were practically free from arsenic.

Fifteen papers were analyzed by Dr. Charles Harrington, of Harvard Medical College, with the result that he pronounced them about the worst lot he had ever tested.

All fifteen contained arsenic, eleven of them large amounts, and six of these very large amounts.

The papers were removed about a month ago, and the patient has been steadily and markedly gaining, so that he has in a measure resumed his business, which he had practically abandoned.

It should be said that the improvement really began shortly before the removal of the papers, under the influence of iron, large quantities of food, and bathing.

It does not appear to me, however, that this militates against the diagnosis of toxic anæmia, and, on the other hand, I do not know to what other cause an anæmia could be due, so profound as this was and so distinctly progressive in character, and yet apparently curable under simple tonics, and occurring in a man of 60, free from grave anxieties and living under thoroughly favorable conditions.

The patient had never presented charac-

teristic local symptoms of arsenic-poisoning, and there had been no other case of serious progressive illness in the house, but the health of the rest of the family had not, on the whole, been good.

Three analyses of the urine, the last of which was made about five weeks after the removal of all the papers, showed that arsenic was being eliminated. During the time of the removal, and for a few days afterwards, the patient absented himself from the house, to avoid unnecessary exposure.—*Therap. Gaz.*, July 15, 1889.

Judkins (W.) on the Deleterious Effects of Cocaine.—Last April a man, fifty-two years of age, subjected himself to the operation (circumcision) for the relief of herpes. Perfect local anæsthesia had been produced, when he suddenly grew faint, presenting all the symptoms of syncope. Cardiac pulsation went down to fifty, but he rallied soon, and was able, after completion of the operation, to take a cab and reach his hotel. Within three or four days he was out and well.

Last Saturday he witnessed a repetition of these symptoms in a patient. He had listened to the heart before the operation, and found the pulse-rate seventy-two per minute. During the operation, with the symptoms of syncope, it went down to sixty. The peculiar feature about the case is that now, three days after the operation, the pulse is still sixty, and to-day, after an exertion of mounting a flight of stairs, it became lowered to forty-eight.—*Cincinnati Lancet-Clinic*, July 13, 1889.

Neilson (T. R.) on Another Instance of the Toxic Action of Cocaine.—The patient was a gentleman, twenty-nine years of age, of nervous temperament, and in good general health, upon whom I performed circumcision in my office on March 6th. The patient refused ether.

Having firmly applied an elastic ligature to the penis, I injected hypodermatically into the skin of the prepuce, at various punctures, a few minims of a four per cent. solution of cocaine hydrochlorate, the total amount used being about forty-five minims, perhaps less. Every puncture of the needle was made at the distal side of the line of circumcision. Anæsthesia was complete, and the operation was speedily performed.

Shortly after the elastic ligature was removed, and while I was preparing the dressing, the symptoms, of what afterwards proved to be cocaine poisoning, began. The patient first complained of feeling "queer," and asked for stimulus, which was given him (about an ounce of whiskey). In a few moments he spoke of an intense desire to urinate, but failed to relieve himself after several attempts. So great was the distress caused by this, that I passed a catheter and emptied the bladder.

The patient appeared excited, and was disposed to be talkative and restless, rolling about from side to side as he lay on the lounge, but there seemed more reason at first to attribute his condition to a moderate degree of shock than to any other cause. Soon, however, other symptoms led me to take a different view of the case. The countenance grew pale, and was bathed in perspiration; there was a slight incoherency; a "crampy" or tingling sensation in the soles of the feet was spoken of; and later, a feeling as of a weight resting upon the precordial region; the features grew pinched, the lips became of ashen hue, the pupils were dilated, the respiration shallow, the pulse slow (forty-four) and of small volume. The patient was greatly alarmed, and implored me not to leave his side, which I wished to do, in order to get my hypodermatic syringe and give him an injection of morphine. Up to this time I had given him only a dose or two of aromatic spirit of ammonia, and some whiskey, to apply a mustard plaster over his heart, and to give him strong inhalations of strong ammonia. In three and a half hours he was able to leave the office. —*University Med. Mag.*, Aug., 1889.

Homans (J., 2d) on Dementia Following Ether.—The first case is that of a domestic, thirty-five years old, of a nervous temperament, who was operated upon at the Massachusetts General Hospital, in 1881, for cancer of the breast. The operation, history, and appearance of the patient presented nothing extraordinary. The second case was a single lady of over fifty, suffering under the uric-acid diathesis, and belonging to a somewhat nervous family, who, in 1884, underwent the ordinary operation for fistula in ano. The cerebral symptoms appearing after the operation, were so nearly similar in both cases that I present them together, the only difference between the two being that of the time at which the various symptoms appeared or disappeared, and that difference only a few

hours, or, in the ultimate recovery, a day or two.

The history of these patients after the operation was as follows: For two days, a condition of euthanasia; patient remarkably happy and comfortable; no pain or discomfort; slightly flushed face; pulse and temperature only slightly raised above normal. On third day, patient a little excited; mind wandered a little, which condition increased till, on the fifth day after the operation, the mind was completely gone; patient tried to get out of bed, or tear off the dressings, and constantly talked or muttered to herself, but with a mild, disconnected delirium, no especial delusions being noted. This condition lasted for about a week, when a gradual improvement began; and in about five weeks after operation the mind was perfectly clear. The first case died in a year or two of recurrence of the cancer, but without any mental trouble. The second patient is now alive and well, both physically and mentally. Here, then, are two cases, both women with somewhat neurotic tendencies, falling into the same demented condition after a not especially severe operation, and both recovering at about the same time.—*Boston Med. and Surg. Jour.*, Aug. 1, 1889.

OCCASIONAL REPORT ON SURGERY.

BY CHARLES A. POWERS, M.D.

Bull (W. T.) on the Treatment of Rupture of the Tendon of the Quadriceps Femoris.—The author, after a careful analysis of all reported cases of this somewhat exceptional injury, concludes that suture of the ends of the divided tendon is advisable, and reports the following case in which he pursued such measure:

A man of fifty-nine fell with the leg flexed and felt something give way. Suffered extreme pain and was unable to walk. Was treated by rest and a posterior splint for three days. When admitted, December 6, 1888, examination showed a depression above right patella admitting finger easily. Absolute loss of extension. Slight effusion into joint. Unnatural mobility of patella.

December 14th.—Patient etherized and an incision three inches long made from upper border of patella upward. Tendon found to be ruptured transversely a quarter of an inch above its insertion. The direction of the rupture was from behind forward and above downward, and the upper end, bevelled in this way, was curled up on itself, leaving a gap half an inch wide on the surface. The rupture extended into the muscular fibres on either side of the tendon for a distance of two inches; the synovial capsule was freely opened, and a slight amount of bloody synovia found in the joint. The ends of the tendon were brought together with four catgut sutures, drainage was established, and the wound was closed. Antiseptic dressing applied and the limb immobilized by a plaster-of-Paris splint. The drains were removed on the seventh day and the splint was renewed.

Rheumatism developed in the ankle of the affected side, and in the opposite elbow. The splints were removed at the end of 33 days. Complete union resulted, but the functions were limited, although Dr. Bull felt reason for believing that they would return.—*N. Y. Med. Jour.*, April 20, 1889.

Allis (O. H.) on the Treatment of Fractures at the Lower End of the Humerus.—The author, in a paper read before the Camden Co. Med. Society, reiterates the opinion which he advanced some years ago, to the effect that all of these fractures should be treated with the forearm fully extended upon the arm. It may be abducted sufficiently to correct the tendency to lateral deformity, and confined for the usual length of time by simple strips of adhesive plaster or by plaster-of-Paris. To the weight of his own large experience Dr. Allis adds the confirmation of Profs. Gross and Agnew. He makes no passive motion; in this he avoids, rather than causes, anchylosis. — *Med. Register*, Dec. 3, 1887.

Van der Veer (A.) on Sub-Spinous Dislocation of Humerus (old.)—A cowboy, æt. 48, was admitted to the hospital November 30, 1887. His case is somewhat rare, there being but few more than thirty cases in the whole literature upon this subject. The accident occurred several months prior to his admission. He was herding cattle with a "bucking" mustang, and was thrown over the mustang's head, striking first on his hand and then on the point of his shoulder. He was seen by a local physician, who claimed to have reduced the dislocation. After the dressing was removed his arm was

powerless. Was unable to touch opposite shoulder by four inches. After consultation, an ineffectual attempt was made at reduction, both by extension and counter-extension, and by fixation of shoulder and manipulation. An operation for the restoration of the head of the humerus to the glenoid cavity was advised, but declined by the patient.—*Albany Med. Annals*, October, 1888.

May (B.) on Amputation of the entire Upper Extremity.— The author gives the indications for operation as follows:

I. Tumors of scapula necessitating removal of the greater portion of the bone.

II. Tumors of upper end of humerus:

1. Benign, if of such excessive size as to render amputation at the shoulder impracticable.

2. Malignant, developed so far as to englobe the articulation: to invade the scapula or the muscles passing from it, the skin over the deltoid, and above all the lymphatic glands in the axilla.

III. Traumatic cases. These are commonly operations of necessity, including such injuries as gun- and cannon-shot wounds with extensive shredding and laceration of integuments round the shoulder; machinery accidents, causing extensive lacerations and comminution of bones, and tearing away of the entire limb.—*Annals of Surgery*, December, 1888.

Moore (E. M.) on the Treatment of Fracture of the Clavicle.—The obvious indications in the treatment of this fracture consist in the use of any bandage or posture that will carry the humerus backward and hold it toward the side. The effect of carrying the arm backward is to move the scapula toward the spine, thus fulfilling the most important indication. But, besides this, the clavicular fibres are rendered tense by this attitude, and thus the only remaining indication is fulfilled. Some aid, perhaps, may be obtained by lifting the shoulder from the elbow, but this is subordinate. In order to obtain the result stated, I have resorted to various devices. I use a shawl or cotton cloth, which (eight inches in breadth at the centre) should be about two yards long. Placing this at the centre across the palm of the surgeon, he seizes with his hand the elbow of the patient which corresponds with the broken clavicle. The two ends of the bandage hang toward the floor. The one falling inward toward the patient is carried upward in front of the shoulder and over the back, making a spiral movement in front of the shoulder. This is intrusted to an assistant. The outer end is then carried across the forearm, behind the back, over the opposite shoulder and around the axilla. This meets the other end which may be carried under the axilla and over the shoulder of the opposite side, thus making the figure-of-eight turn around the sound shoulder.

The forearm should be sustained by a sling which raises it to an acute angle in order that gravity may assist in moving the whole arm backward. Any tendency on the part of the shawl to slide from the shoulder may be arrested by a pin thrust in at the crossing. The shawl at the elbow is kept in place by folding the upper part that fits the arm and securing it by a pin. This makes a sort of cup for the elbow. It will be observed that the shawl, as it passes in front of the arm, does not press upon the axillary border of the pectoral muscle, and, therefore, avoids the objection of the ordinary figure eight. It passes over the forearm and over the opposite shoulder; it lifts up the arm like the ordinary shawl bandage.—*Med. Press, Western N. Y.*, Feb., 1889.

Adamkiewicz (A.) on the Transplantation of Bone.—As the result of a vast number of experiments, the author has arrived at the following conclusions, which, in the first place, had been deduced from experiments on the rabbit:

1. Round plates of bone of a diameter of from 0.6 to 0.9 centimetres, which had been removed from the skull of the rabbit and inserted again into the opening, united perfectly with the surrounding bone, if the usual precautionary antiseptic measures were taken at the operation.

2. The length of time which was necessary for this process to take place was between four and six weeks. At least, the author had observed, after from four to six weeks, a perfect synostosis between the implanted piece of bone and the other bones.

3. The piece of bone to be transplanted could be exposed to the air for a certain time (from five to ten minutes) or could lie in a solution of carbolic acid (two to three per cent.) without preventing the success of the experiment.

4. Still larger pieces of bone, more than a centimetre long, and correspondingly

broad, whose edges were not even smooth, also united with the skull, when implanted with the same precautions.

5. In the same way pieces of bone could be transplanted from one animal to another with equal success.

6. The osseous intergrowth occurred on the borders of the bones which touched each other, for these ossified and became more and more indistinct, whereas the free surfaces of the bones preserved their usual form and smoothness. In cases in which the implanted piece of bone did not touch the border of the surrounding bone, the union took place by the formation of connective tissue, and not by ossification, so that it might therefore be concluded that for an osseous union to occur the direct contact of the bones was of great importance.—*Letter to N. Y. Med. Jour.*, June 29, 1889.

[Dr. F. W. Murray, of this city, showed, at a recent meeting of the Hospital Graduates' Club, the skull of a man whom he had trephined some six weeks previously for possible supradural hemorrhage. No lesion being found, the removed button of bone was replaced. The man died four weeks after, from undetermined causes, and at the autopsy it was found that the replaced fragment had contracted firm union with the surrounding skull.—C. A. P.]

Senn (N.) on Fractures of Neck of Femur.—The author, after a careful and critical study of a large number of cases, draws the following conclusions:

1. From a scientific, prognostic, and practical standpoint it is not necessary to make a distinction between intra- and extra-capsular factures of the neck of the femur.

2. An impacted fracture of the neck of the femur will unite by bony union, provided the impaction is not disturbed and is maintained by appropriate treatment for a sufficient length of time for the fragments to become united by callus.

3. Impacted fractures of the neck of the femur should be treated by a fixation dressing consisting of a plaster-of-Paris case, including the fractured limb, the pelvis, and the opposite limb as far as the knee, in which a splint should be incorporated by which lateral pressure can be secured in the direction of the axis of the broken femoral neck.

4. Unimpacted fractures of the neck of the femur, both intra- and extra-capsular, should be treated by immediate reduction and permanent fixation, so as to place the fragments in the same favorable condition during the process of repair as in impacted fractures.

5. Reduction is effected most readily by auto-extension and traction upon the fractured limb with the patient in the erect position, resting his weight upon the sound limb.

6. The fixation dressing should not be removed and the lateral pressure should not be discontinued for from ten to twelve weeks, the shortest space of time required for bony union to take place.

7. Patients who have sustained a fracture of the neck of the femur should not be allowed to use the fractured limb earlier than four to six months after the accident, for fear of establishing a pseudo-arthrosis at the seat of fracture.

8. The functional result is greatly improved by passive motion, massage, and the use of the faradic current.—*Jour. Am. Med. Assoc.*, Aug. 3, 1889.

Bird (F. D.) on Fracture of the Second Rib.—Mrs. M., lifting one side of a heavy chest, felt a sudden tearing pain in the front of the left side of her chest and down the left arm, which became powerless.

The next day, the 20th of March, she consulted me. To my surprise, on making a careful examination, I detected crepitus, and there was evidently a fracture of the second rib on the left side, about one and a half inches from the costal cartilage.

About fourteen years previously this lady had received an injury over the upper part of the left side of the chest, which soon got well, and never troubled her since. Strapping and the application of a Martin's bandage effected union in the rib, since which she has suffered no pain whatever in the part.—*Australian Med. Jour.*, May 15, 1889.

[A possible, though not certain, case of this rare fracture. It is more probable that a muscular attachment was partially torn, and that blood effusion occasioned the presence of a hemorrhagic crepitus. Simple "crepitus" is not positive proof of fracture.—C. A. P.]

Abbe (R.) on Dupuytren's Finger Contraction.—The author, than whom no surgeon is better qualified to speak on this subject, reiterates these conclusions at which he arrived five years ago regarding the causation of the trouble:

First.—A slight traumatism of the palm, often entirely forgotten.

Second—A spinal impression produced by this peripheral irritation.

Third.—A reflex influence to the part originally hurt, producing insensible hyperæmia, nutritive-tissue disturbances, and new-growth, shown in the contracting bands of fascia, and occasional joint-lesions resembling subacute rheumatism.

Fourth.—Through the tense contractions a second series of reflex symptoms, neuralgias, general systematic disturbances, and a reflection of the trouble to the corresponding part of the opposite hand.

Subsequent cases have strengthened his belief that the foregoing conclusions are correct for these reasons :

First.—Very few cases of Dupuytren's contraction have specially strong hereditary or personal predisposition to gout, and many have no taint whatever of either rheumatism or gout.

Second.—No case I have yet seen has had both hands affected simultaneously. An interval of from a few months to several years occurs between them.

Third.—The neuroses of scar tissue in various parts of the body are universally recognized by surgeons and specialists, and are analogous to those accompanying Dupuytren's contraction.

Fourth.—The neuroses of which I shall speak are secondary to the development of the palmar bands, and can be started up oftentimes by hurting these.

Fifth.—The neuralgias and neuroses are usually relieved by operation, oftentimes as if by magic.—*Med. Record*, March 5, 1888.

Fowler (George R.) on the Justifiability of Resecting the Knee-Joint for Tubercular Infiltration in Children.—The author summarizes as follows :

First.—Observation and clinical experience show that tuberculous inflammation within or in the neighborhood of the knee-joint, in children, leads to relative shortening of the limb, through interference with the blood-supply to the epiphyseal cartilages.

Second.—The amount of shortening of the limb present, when the patient reaches his full growth, will depend upon the extent to which the epiphyseal cartilages have been damaged and its bone-forming function destroyed by the presence of the tuberculous disease.

Third.—Resection of the knee-joint in growing individuals is followed by relative shortening of the limb only in proportion as the line of the epiphysis has been invaded by the disease. The extent of the disease is the only guide for the surgeon to follow in determining the amount of tissue to be removed. Those cases in which the epiphysis is spared, and in which the ultimate relative shortening is found to be considerable, are cases in which the damaging effects of the disease are responsible for the functional disability, and not the operation.

Fourth.—Resection of the knee-joint in children is justifiable. Attempts to preserve the epiphyseal cartilages where the latter are actually invaded by the tuberculous process can hold out no hope of lessening the ultimate relative shortening, and will almost certainly lead to a recurrence of the disease and the necessity for final amputation.—*Annals of Surgery*, June, 1889.

MISCELLANY.

A New Remedy.—While working in the chemical laboratory of the Society of Physicists in Frankfort-on-the Main, Herr H. Baum, chemist, recently discovered a substance which is likely to compete with salicylic acid as a remedy and antiseptic. This new substance, dithio-salicylic acid, consists, as it were, of two molecules of salicylic acid concatenated into one molecule by two atoms of sulphur. The well-known bacteriologist, Professor Hueppe of Wiesbaden, has ascertained that a 20-percent. solution of sodium-dithio-salicylate kills anthrax spores in forty-five minutes, whereas sodium-salicylate under the same conditions has no perceptible effect. Its effect on cholera and typhus bacteria, on the bacterium of green pus, and on the staphylococcus aureus, is much stronger than that of sodium-salicylate. Sodium-dithio-salicylate II. (there is a similar substance called sodium-dithio-salicylate I.) has been tried in many cases of acute rheumatic fever in Dr. Knoblauch's wards in the city hospital of Frankfort, and Dr. Lindenborn reported on these experiments in No. 25 of the *Berlin Clinical Weekly*. In the slighter cases a dose of 0.2 gramme was given every morning and evening ; in the severer ones the same dose every morning, and two, three, or four times an hour every evening. In slight cases pain, fever,

and swellings disappear after two days; in severer ones, after six days at most. As compared with sodium-salicylate, sodium-dithio-salicylate possesses the following advantages: stronger effects and consequent adequacy of smaller doses; no bad effects on stomach, heart, and vessels; no collapse, no humming in the ears. A Frankfort physician had given a patient, who was suffering from acute rheumatic fever, 200 grammes of sodium-salicylate without any essential alleviation. He then tried the new remedy, giving the patient four doses of 0.2 gramme daily, which cured him in five days.—*Lancet*, Aug. 17, 1889.

Peterson (F.) on Exalgine.—Case I.—A. S——, female, aged twenty-four, suffering from trigeminal neuralgia, upper two branches, and extending also over occipital region, of several years' duration. It is proper to say that many remedies had been tried unavailingly. Two grains of exalgine were ordered every three hours. She took nine doses without any relief of pain, drowsiness, or apparently any effect. Aconitia and quinine prescribed since have also failed to secure relief.

Case II.—K. G——, female, aged nineteen, for a week or so had had cephalalgia, neuralgic in character, over the whole of the right side of the head. She could not sleep on account of the pain, and, as she expressed it, "was driven nearly crazy." There was good reason for suspecting the case to be malarial, and quinine was administered for some ten days, five grains three times daily, without, however, any effect. She was then ordered exalgine pills, āā gr. ij. every four hours. She took but four doses, and reported complete cure.

Case III.—A. W——, female, aged fifty, a paranoiac, troubled excessively by paræsthesiæ over the whole body, which gave rise to the delusion that electricity was being used upon her continually by her persecutors. Sleepless much of the time, because of these shooting pains and prickling sensations. For two nights she took exalgine, one dose only of two grains each night, and slept soundly, the pains not recurring until morning.

Case IV.—S. H. B——, male, aged fifty-two, supra-orbital neuralgia for three months. Pain much diminished by exalgine, gr. ij. every four to six hours.

Case V.—S. D——, female, aged thirty-six, occipital neuralgia for two months past, of probable malarial origin. Twenty grains of quinine daily for three days produced no effect. Exalgine was ordered in two-grain doses every four hours for several days. Patient stated that she felt a sort of drowsiness, but the pain was not diminished in the least.

Case VI.—J. D.——, male, aged sixty, occipital and supra-orbital neuralgia of some weeks' duration. Was treated with quinine and apparently cured. The pain returned, however, in three days, and quinine was employed again without effect. Antifebrin was then used, and also failed to relieve the pain. Exalgine was then given in two-grain doses every four hours, and effectually banished the pain for some days. On its subsequent return exalgine proved of no service, except to permit him to sleep at night, although given in the same doses every two hours. He complained of a singular feeling of numbness all through his body after the use of the drug.

Case VII.—M. M——, female, aged thirty-five, morphine habit for three years, taken for a pain in the side. The original cause of the pain was a fall several stories down an elevator shaft. The daily amount of morphine taken for the pain is small, seldom more than three grains. The disease seems now to be a morphine neuralgia. Exalgine pills were substituted for several days, two grains every two or four hours. While she acknowledged some relief of pain, other disagreeable effects were produced—drowsiness, nausea, dilated pupils, and diarrhœa; previously there had been myosis and constipation. It is probable that the pupils appeared dilated, merely because of the relaxation of the iris from the cutting off of morphine. Patient felt compelled to return to her favorite habit, and as any quantity of morphine she may desire is provided for her by an indulgent mother, there was no obstacle to her so doing.

Case VIII.—M. A——, female, aged sixty, brachial neuritis. There was first a severe brachial neuralgia, with a herpetic eruption over the whole extent of the median nerve. After recovery of the herpes, there was intense pain and tenderness along whole arm, particularly about fingers and wrist, and with trophic changes in the skin and muscles of those parts especially. For the amelioration of the pain exalgine was given first in pill form, later in the

form of the cordial exalginque, in doses of some two grains each, every four to six hours. The effect has been excellent. The cordial seems the better form for administration in this case, and has been relied upon for three weeks as an analgesic. No ill results have followed its use.

In addition to these eight cases, of which notes are given, exalgine was given experimentally in some twelve cases of various forms of cephalalgia, in the two-grain doses several hours apart, and with benefit in about fifty per cent. The doses, as is evident, have been minimal, and where the analgesic quality of the remedy has not manifested itself, it is probable that double or triple quantities at one dose would have proven efficacious. Upon the whole no bad effects were produced, except, possibly, some in the case of morphine habit, and in certain of my cases it was a decidedly useful medicament. The doses employed by the French physicians who introduced the remedy were, as has been stated, from four to six grains, and from my experience I should in most cases begin with four-grain doses every two to four hours. With smaller doses the analgesic effect may be uncertain in its development. —*Med. Record*, Sept. 14, 1889.

Hepburn (J.) on Successful Treatment of a Case of Dysentery by Strong Enemata of Alum.—On June 4th I was called to see a woman, aged twenty-seven, whom I found was suffering from a severe and well-marked attack of dysentery. The patient stated that she had that day returned from the country, where she was in service; her illness had lasted six weeks, during which time she was under the treatment of local medical men; but as her condition was gradually becoming worse, she had been advised by them to return to her home. She complained of violent purging (about twelve stools in the twenty-four hours), accompanied by pain and tenesmus, the stools being liquid, very offensive, and bloody; she also suffered from constant nausea and vomiting. Lead, opium, bismuth, ipecacuanha, Dover's powder, and many other astringents were tried in various combinations, but with very little success. On June 10th, as she was no better but gradually becoming weaker, I though it advisable to try some other plan of treatment. Accordingly I ordered her two enemata daily, each containing half an ounce of alum to the half-pint of water. The first injection brought away a good deal of "dirty stuff," presumably shreds of tissue and sloughs, and caused a certain amount of smarting pain; this, however, subsided after a short interval, the patient reporting that she felt much more comfortahle; her condition then began immediately to improve, the tenesmus becoming less, the stools not so frequent and more solid, and the sickness ceasing. The second injection caused less pain, and the improvement continued. The same treatment was followed on the next day (June 11th). She was now so very much better (the stools being only three in number in the twenty-four hours, with only streaks of blood) that on the ensuing day the enemata were omitted; but on the 13th she relapsed, the stools becoming more frequent. I then thought it advisable to resume the injections; accordingly two were administered on the 14th, the same good results following them as on the former occasion. This treatment was continued till the 17th, the patient improving day by day. From the 17th till the 21st one injection a day was found sufficient, and, finally, on the latter date they were left off altogether, the patient having made a perfect and uninterrupted recovery from the 14th.

That the favorable termination of the case was entirely due to the enemata I think is sufficiently proven: first, by the good results obtained from the first two injections and rapid relapse on leaving them off on June 12th and 13th; secondly, by the absolute recovery of the patient in seven days after an illness lasting over eight weeks, during seven of which purging with tenesmus and bloody stools, nausea, and vomiting had existed in varying degrees of severity.—*Lancet*, Aug. 31, 1889.

Exalgine. — The methylacetanilide, which has been diagnosed "exalgine," is another body belonging to the inexhaustible aromatic series. It has been largely experimented with on the Continent, and the French have welcomed it with open arms as a means of fighting the German monopoly of antipyrin. All the bodies belonging to this series possess antiseptic, antipyretic, and analgesic properties, but in different degrees. In some, the antiseptic action is predominant, while in others the antipyretic effect is so marked as to disguise the two remaining properties. Antipyrin represents a medium product in

which the antipyretic precedes the analgesic effect. Exalgine, on the contrary, is claimed to be an indifferent antithermic agent, but to possess in a supreme degree the analgesic properties which have made antipyrin such a popular and valuable remedy. It is prescribed in much smaller doses than its German rival, and, like all new drugs of this class, is said to be devoid of the particular drawbacks attending the use of the drugs which it is intended to supplant.—*Med. Press*, Aug. 21, 1889.

Hare (H. A.) on the Frequency of Certain Premonitory and After-Symptoms in Epilepsy.—From a collection of 970 histories of epileptics the following results were reached: In only 158 instances out of 970 cases collected was any thing said concerning the side most affected by the fit, and of these 158 cases it was found that the right side was most affected in 77 instances, and the left was most affected in 81 instances, results which agree with the statistics of most other writers.

In respect to the frequency of the aura and its character, I found that it was noted as present, in some form, in 362 cases out of the entire number, and absent in 138.

The forms of aura most commonly felt were as follows, being arranged in the order of their frequency:

Tingling	45
Visual	27
"Painful"	26
Twitching	21
"Epigastric"	20
Headache	16
"Auditory"	16
Dizziness	15
Numbness	15
Disturbed Respirations	14
"Gastric"	15
Cramps in muscles	11
"Olfactory"	11
"Mental"	8
Chilliness	7
Faintness	3
"Abdominal"	3
Aphasia	3
Unclassified	44

The occurrence of coma is noted as present in 104 cases, and as absent in 12 cases, but this number is probably incorrect, since unconsciousness is a much more common after-symptom. It would appear, however, from the history of the cases that the coma in these instances surpassed in its severity the mental hebetude so often seen. In 101 cases only is any statement made as to rotation of the body in the fit, and of these 49 rotated to the right, and 52 to the left; so little difference as to make it appear that both varieties are equally common.—*University Med. Mag.*, Sept. 1889.

The Inhalation of Dust.—Dr. Kunze, in his inaugural thesis for the M.D. degree of the University of Kiel, publishes as a contribution to the diseases caused by the inhalation of dust a series of examinations of lungs so affected. In all these dust was found microscopically, and after chemical tests in the various anatomical and histological parts of the lungs and in the interior of the lymphatic vessels numerous leucocytes were found covered with the dust. Being arrested in its progress, it causes inflammation producing hyperplasia of connective tissue, especially where a dense network of lymphatic vessels exists. Dr. Kunze also proved that the degree of alteration in so-called "dust lungs" depends not merely on the quantity of the dust inhaled, but also on its greater or less morphological power of injuring the tissue. He concludes from his experiments that even the greatest alterations in these lungs—such as nodes, indurations, and vomicæ — are mainly produced by the inhaled dust, and that tuberculosis is only an occasional coincidence. The least serious alterations in the lungs resulted from the inhalation of lamp-black, the particles of which are very fine and little injurious; the most serious, from the dust inhaled by earthenware manufacturers and stone-masons. The lungs of a locksmith showed only a moderate hyperplasia of connective tissue, the dust consisting partly of the finest particles of iron. In a worker in oxides of iron the lungs were found full of small granules, and the morbid changes in the tissues were very considerable. The lungs of gold miners were generally indurated and atrophied; the dust in these cases is exceedingly fine. Sand produced numerous circumscribed hard nodules and thick indurations. In cloth manufacturers, the lungs, in spite of their contact with an enormous quantity of organic dust, presented but few indurations. In the lungs of two stone-masons induration and tuberculous disintegration were observed; all the other lungs were entirely free from tuberculous of any kind, an observation which was verified by the absence of tubercle bacilli in the muco-pus in the vomicæ.—*Lancet*, Aug. 24, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLE.

Adoption of Ether by the English.—It is with pleasure that we note some quickening of the English conscience with regard to the continual use of chloroform as an anæsthetic.

All honor also to the man who, in the face of such prejudice as has always existed in favor of chloroform, dares to advocate the adoption of its equally efficient and much safer substitute.

Before the British Medical Association, at its recent meeting at Leeds, Mr. T. Pridgin Teale, M.A., F.R.C.S., F.R.S., gave an address in surgery, entitled "Detail in Surgery," in the course of which he made the following remarks on "Ether *versus* Chloroform."

"This is a subject on which I wish to speak with a sense of grave responsibility—the more so that I have to express views which are strongly opposed to those uttered at Glasgow last year by my predecessor in this chair.

"If any one asks why I venture to differ so widely and strongly from one whose surgical experience is probably not less than my own, and may be greater, my plea is as follows:

"For the first fifteen years of my surgical life, which includes ten years as surgeon to the Leeds Infirmary, I knew little of any anæsthetic but chloroform. So far, probably, our experience runs parallel. During the last fifteen years ether has almost superseded chloroform in my practice. Here the parallel ceases. Sir George Macleod's second fifteen years are still devoted to chloroform. He cannot speak from fifteen years' experience of ether. As a result of the comparison of these two periods I unhesitatingly assert that ether is, for safety to the patient and for comfort and convenience to the operator, immeasurably the better anæsthetic of the two. Either can be given '*tute, cito, et jucunde!*' I say can be; would that I could say *is* always so given.

"My earliest experience of ether was in the method introduced by Dr. Joy Jeffreys, when, at the International Ophthalmic Congress in 1872, he preached his crusade against the almost universal use of chloroform prevalent in the United Kingdom, and compelled British surgeons to take up the question of ether. He appealed to our sense of duty in reference to the fearfully increasing fatality of chloroform, and we responded to his call, in spite of the grave disadvantages, of the clumsy, wasteful, nay harmful, method of giving ether by lavishly pouring into a cone formed of a towel, to which he introduced us. The disadvantages of ether so given were great and obvious. The struggling of the patient, the icy coldness of the inhaled air, the saturation of the air of the room by 12, 15, or 20 ounces of ether spent upon a single case, and the not infrequent, and occasionally fatal, bronchitis which followed, were such obvious drawbacks that the wonder is that ether survived as an anæsthetic in England, until it had time, by improved methods and increased experience, to win its way to the pre-eminent confidence which it now

commands. The towel was, after a time, superseded by the wicker grid—brought over from America by a late chaplain to the Leeds Infirmary, the Rev. E. Spencer Gough,—an improvement on the towel, but sharing with it the chilling of every inhalation by the evaporating ether, as well as a high percentage of waste of the anæsthetic. The method of administering nitrous oxide gas before giving ether was, in his later years, largely given up by Clover. Next came the great step, which was the saving of ether as a British anæsthic. Ormsby, of Dublin, invented the inhaler in which the exhaled warm air, charged as it is with ether, was received into an india-rubber bag and breathed over and over again, thus economizing the heat of about 90 per cent. of the exhalations and reducing the waste of ether. This idea was taken up by Clover and developed into the present form of inhaler, which, as far as I know, is unapproached by any method of giving ether that has come into use. But '*non cuivis homini contingit adire Corinthum.*' It is not every one who knows, and there are some who are incapable of learning how to administer ether, even whith Clover's inhaler.

"There are many hospitals in England, and still more, I believe, in Scotland, where the use of ether is practically unknown, or where, if ether is given, the obsolete towel or the grid, or the very inferior inhaler of Ormsby is used; or even should the hospital possess a Clover, it may not possess an etherist who knows how to use it to the best advantage. To administer ether badly is to bring it down nearly to a level with chloroform as to safety, and to render it inferior to chloroform as to comfort to the patient. A bad etherist will cause fear, coughing, distressing sense of suffocation, excitement, struggling, blueness of lips, mucous rattling in the trachea and bronchi. He will take many minutes, five to ten, in getting his patient under the anæsthetic, will use twice or thrice as much ether as is needful, will keep his patient when unconscious overcharged with ether in a state of profound stertor, and will now and then set up a dangerous bronchitis. A good etherist will win the confidence of his patient, even of the most timid, by judicious encouragement, and by first applying the mouthpiece alone. As confidence becomes established he adds the reservoir and then the india-rubber bag, slowly turning on the ether as tolerance of the vapor becomes established, and unconsciousness begins to steal on. Then he more rapidly increases the proportion of ether, and the patient quickly falls into compete anæsthesia. Such an administrator will, in nine cases out of ten, have his patient ready for operation in two or three minutes, and not infrequently in about a minute and a half, without a struggle, without coughing, often without even a transient sense of suffocation, and with the expenditure of about half an ounce of ether, and will but need about one ounce of ether for each quarter of an hour that the anæsthesia is kept up. In such a case we need fear no danger at the time, nor subsequent bronchitis. So much for the patient.

"But there is another side of the ether question which I have never seen adequately stated. The advantages to the operator of using ether instead of chloroform are very great. In the first place his anxiety is less, his fear of a fatal issue is less, and when obliged to trust to an inexperienced administrator, as he must do at times in sudden emergencies, he can more efficiently keep an eye on the patient's condition, and superintend the administrator, than when chloroform is used.

"In the second place there is a saving of time, a patient being brought under the influence of ether in two or three minutes, whereas chloroform, in my experience, needs eight or ten. Such a saving is of no slight moment in modern hospital practice now that the sphere of surgery has become so enormously extended.

"In the third place, under ether return of consciousness to pain generally lags behind the return of mental perception, and thus anæsthesia can easily be re-established without interrupting the operation. So marked is this fact towards the end of a prolonged operation, that sometimes the surgeon may continue to operate for ten minutes or a quarter of an hour without re-application of the inhaler, and even converse with his patient whilst stitching up a wound. This is hardly, or rarely, the case with chloroform. Let any one who is not yet a convert to ether, or who, having used ether, is wavering in his allegiance to it, ask himself these questions. Have I myself studied the details of successful etherization? Am I using the best form of inhaler? Have I taken pains to have those who act for me properly taught and trained? If not, let

him ask himself one more question—have I done my duty?"—*Br. Med. Jour.*, Aug. 17, 1889.

OCCASIONAL REPORT ON OBSTETRICS AND DISEASES OF CHILDREN.

BY ELIZABETH STOW BROWN, M.D.

Teratological Contributions. — Dr. Walter reports the case of a double female monster, born at the eighth month of utero-gestation, after a labor natural as far as presentation and passages are concerned. (*Brit. Med. Jour.*, June 22, 1889.) The double sets of limbs were perfect in every respect, as also were the spinal columns, backs, and shoulders. The anterior walls of the chest and upper part of the abdomen were joined together, and the umbilical cord arose from the junction of the two bodies. The anterior and lateral parts of the head appeared as one large head, the eyes, nose, mouth, and ears being perfect. At the back of the head was a shallow longitudinal sulcus, in which appeared two more ears. The head was well covered with hair. The weight of this monster was about six pounds.

Dr. Cæsar describes an amelus or limbless monster which was born at full term. (*Brit. Med. Jour.*, March 9, 1889.) The monster consisted of a head and trunk fully developed, but no trace whatever of a limb, no appearance of intra-uterine amputation having taken place; no scapula or clavicles, and no acetabula, simply a fully developed male trunk. There was a hernia of the small intestines.

Dr. Morgan (*Cincin. Med. Jour.*, July 15, 1889,) reports a case of double monster, twin girls, with united bodies, one week old at time of writing. The heads, arms, and legs are normal, but their bodies are joined at the abdomen, with one umbilical cord. The spine in each case curves to the left, and the legs of each child are upon the left side; between these are located the vagina and anus of each child, both performing their proper functions. The vital organs of both children are perfect, distinct, and separate. Frequently one sleeps while the other is awake and active. At birth they weighed twelve pounds. The delivery was easy. It was attended by a midwife.

Dr. H. C. Dunnaraut (*St. Louis M. & S. Jour.*, July, 1889,) reports that he recently delivered a woman of a dead child about six months advanced, and while searching for the secundines he discovered another child. After its expulsion he found it to be an Acephalobrachus. There was no sign of a head and none of a right arm; a short stump with four fingers represented the left arm. The lower extremities were well formed but lapped from the knees, inwardly, with only four toes on one foot and five on the other, one of the latter being on the bottom of the foot. Where the sternum should have been there was an opening about two and a half inches in width at its upper part, tapering below to a point. This opening exposed the lungs, showing them to be but feebly formed. The heart was small and quite imperfect. As before indicated, there was no sign of brain tissue.

Mr. Nisbet, M.B., writes in the *Brit. Med. Jour.* of July 6, 1889, of a child which he delivered, and which presented the following peculiarities: there were no legs at all, nor apparently any acetabula on the pelvic bones. Attached to the buttocks on each side was a small appendix of skin about an inch in length, in shape and size closely resembling the little finger of a newly born child. The pelvis seemed abnormally broad; but this was only apparent, being due to the absence of extremities. These appendages presented none of the appearance of stumps, and the abnormality was evidently not due to intra-uterine amputation. An arrest of development had also taken place in the right arm, as the limb was only about half its proper length; there was no elbow-joint, and the hand seemed to articulate with the lower end of the humerus. The left arm was distorted so as to look like claws more than fingers. A curious point was that the coccyx projected externally, carrying the skin with it so as to clothe it, and thus forming a rudimentary tail about three quarters of an inch in length. The head, chest, and abdomen were normal to all appearance. The infant proved strong and grew rapidly, and at the time of writing, is, to the best of the writer's knowledge, living still. If so, it is about 18 months old.

Prof. Widerhofer describes under the name of "amniotic umbilicus," a curious and rare abnormality in which the amniotic sheath of the umbilicus, instead of becom-

ing continuous with the skin of the abdominal parietes at the ring, spreads out and replaces the skin over a zone of variable extent surrounding the insertion of the cord. In the case under observation, the infant, a day old, had been thought by the midwife to be suffering from umbilical hernia. The sheath replaced the skin over an area some two inches in diameter and in appearance resembled a placenta in miniature, seen from the fœtal side. In due course the stump of the cord underwent the usual retrogressive changes and the amniotic disc also slowly participated therein, the whole coming away together by the tenth day. There remained a granulating surface on the site of implantation of the amnion which healed in about six weeks, leaving a stellate cicatrix the size of a sixpenny piece.—*The Med. Press*, July 17, 1889.

Mulligan (E. W.) on a Case of Fœtus Papyraceus.—The patient, who was pregnant six months, had intermittent pains in November, 1888. The author, thinking delivery would take place in due time, left the patient with instructions to summon him when the pains became more severe and rapid. At this time the abdomen was very large. She was not seen again till Feb. 28, 1889, when she was found again in labor, and this time her abdomen was much smaller than when she was seen three months before. In an hour a ten-pound boy was born, and immediately following this, a dead fœtus, well preserved. The dead child was flattened out, so that it took up but little space. It appeared to be a six-months' fœtus. The cord was slightly attached to the border of the placenta. On enquiry concerning the patient's illness three months before, she said that soon after the physician left her, the bag of waters broke, and almost a pailful of clear fluid escaped. After this, the pains subsided. Probably at that time both children were alive, but, after the rupture of the sac and escape of the amniotic fluid, one died. The case is of interest to show that a dead fœtus can be retained in the uterus for three months and no harm come to the mother.—*Buff. Med. and Surg. Jour.*, Aug., 1889.

Dr. Mulligan reports in the same article a case of double vagina and uterus. The patient was a well-developed young woman, twenty-five years old, married two years, without any children. The external genitals were normal. The vaginæ were situated side by side, the opening to the left one being a little above the right. They appear to be about the same size, but the right one having been used, received the speculum more easily. Each uterus was 2½ inches in depth, and the os normal in both. The patient had had two miscarriages in the past three years, miscarrying each time when two months pregnant.

Grimshaw (Thomas Wrigley) on Child Mortality in Dublin.—The author, who is the President of the Statistical and Social Inquiry Society of Ireland, presents a grim picture of child-life in Dublin. Recently a movement has been started in Dublin for the prevention of cruelty to children, and the object of the information gleaned by the writer is to show the necessity there is for taking measures to improve the conditions of the life of children in Dublin.

The deductions of the paper are drawn from statistical tables compiled from numerous points of view.

By comparing the annual death-rate per 1000 among infants under 12 months and for children under five years, in England, Scotland, and Ireland, it is shown that the death-rate of infants and young children is much lower in Ireland than it is in England or Scotland. One cause of the lower mortality of children in Ireland than in England and Scotland is owing to the fact that the proportion of the population of the sister countries living in towns far exceeds that of Ireland, and the death-rate of town children far exceeds that of country children. The death-rate of town populations is greater than that of country populations, but at early ages this excessive death-rate is much accentuated. A comparison of the child mortality of Dublin with that of other large towns in neighboring counties, shows that it is comparatively high not only as compared with English and Scotch towns, but also with the large Irish cities, Belfast and Cork. Dublin has the highest general death-rate, also, as well as the highest child death-rate.

It has been generally found that when there is an excessive birth-rate there is an excessive death-rate, the rate being raised by the deaths among children, and thus the cause of the high death-rate, both general and infantile, has been explained for the population of manufacturing towns. Married women working in mills, being un-

able to nurse their own children, are more liable to frequent pregnancies, and their children, being artificially fed and not having the proper amount of maternal care, are more liable to disease and death than the children of country mothers. Dublin, however, is not a manufacturing town in the sense which necessitates the large employment of women, married and unmarried, in mills and factories; the birth-rate of Dublin is not high. Therefore this class of causes of high death-rate among children does not exist to any appreciable extent in Dublin. The four following have been assigned as the main causes:

1st. The large proportion of very poor in Dublin.

2d. The inferior house accommodation of the artisan and laboring classes.

3d. The habits of the people.

4th. Carelessness with regard to children in general, and of sick children in particular.

From a table showing the death-rate for the several social classes in Dublin, it is found that the general death-rate in the "Professional and Independent Class" was 13.8 per 1000 as against 34.8 per 1000 in the "General Service and Inmates of Workhouse Class." In children under five years of age the difference is still more remarkable, the rate being 18.2 per 1000 for the "Professional and Independent Class," and 116.9 per 1000, or over six times as much, in the "General Service and Inmates of Workhouse Class."

As to the house accommodation of the lower classes, the author has shown in a previous paper that the concentration of families in single houses is very great.

The habits of the people are of such a nature as to lead to negligence of young children. It has been demonstrated by the criminal statistics of large towns, that there is a close relationship between the rates of mortality and the rates of drunkenness, and there can be little doubt that the extremely intemperate habits of the lower classes of the people of Dublin has much to do with the high death-rate among children. The children of drunken parents are not born healthy, and in infancy are neglected in every conceivable way, and are exposed to dangers from reckless negligence, which are almost inconceivable among civilized people. In 1886 Dublin was distinguished by having the highest drink-rate in the United Kingdom. Hence it is seen that the high drink-rate of Dublin corresponds with a high infant mortality.

The carelessness with respect to child-life in Dublin is shown by the large proportion of children who die without being medically attended during their last illness. From a table compiled to show the number and proportion of deaths from certain non infectious forms of disease, which are the main causes of death among young children, it appears that 24.1 per cent., or nearly one-fourth of all the deaths among children under five years of age, are ascribed to convulsions. Many of these may be cases of bad food, gross negligence or injury, concerning which no particulars could be ascertained, there being in many instances no medical attendant at all, and in others only a medical attendant called in at the last to see the child die in convulsions, but without having had the opportunity of ascertaining the previous nature of the disease.

Many of the cases of meningitis appear to originate in knocks on the head, either by accident or design, through carelessness, or cruelty. Many cases of diarrhœa originate in bad, or badly prepared food; and this cause also operates actively in promoting mesenteric disease. The frequency with which young children are shut up alone, leads to many accidents; among others, to accidents by fire, often of a terrible character.

It is to be hoped that this report of the melancholy state of the children of the Dublin poor, may rouse Dublin's more enlightened citizens to efforts to better their condition.—*Dublin Jour. of Med. Sc.*, July 1, 1889.

Cheesman (T. M.) on an Apparatus for Sterilizing Milk.—To Professor Soxhlet is due the credit of first sterilizing milk for infant feeding, and Dr. A. Caillé first introduced the practice to the profession in this country. The apparatus known as the "Arnold Steam Sterilizer" presents certain advantages over that which is recommended by these gentlemen.

Sterilization is accomplished by bringing the object to be sterilized to the temperature of live steam, and maintaining it at that temperature for about forty-five minutes. Boiling for the same length of time, in a vessel the sides of which are exposed to the air, is not sufficient, as the temperature

in different parts of the vessel is found to vary considerably. This is the main objection to Soxhlet's apparatus, the principle being that of a water-bath. In the "Arnold Sterilizer," it is a steam-bath, in which variation of the temperature is prevented.

It is recommended to any who might use this apparatus, that the food be prepared as it is to be administered, and that the quantity required for twelve or twenty-four hours' feeding be distributed in eight-ounce flasks or nursing bottles, providing one such bottle for each feeding. In filling the bottles a funnel should always be used to keep the necks clean, and the fluid should be a full inch below the neck. The bottles should be plugged with cotton, extending well down into the neck, any impurities which this may contain, in the form of moulds or bacteria, being destroyed by the same process which sterilizes the food. The bottles are then placed in the cold receiving vessel [to prevent breakage], and heat is applied by means of gas, or a kerosene or coal stove. Heat must be maintained for an hour and a quarter. Food thus prepared can be kept at ordinary temperatures for an indefinite period, doing away entirely with the use of an ice-pail or refrigerator for keeping the milk sweet. When the food is to be given, the bottle is to be well shaken to mix in the cream, the cotton plug is removed, and the nipple applied to the bottle at once. In cases where it may be necessary to administer food at a higher temperature, the bottle is placed in warm water, as is customary. It is not practicable to sterilize the nipple, as heat destroys the rubber, but they can be thoroughly cleansed by the ordinary methods.—*N. Y. Med. Rec.*, July 13, 1889.

Keating (John) on Milk for Infants in Summer.—The author remarks that the only animal he knows of that is not endowed by nature with an instinctive knowledge how to care for its offspring seems to be the human mother. It is a question to be met how to supply the poor with pure milk, especially during the summer-time. The only practical way to get out of this difficulty is: first, to make such stringent laws as will permit only the sale of pure milk; second, to devise some simple means by which any milk that happens to be tainted can be rendered harmless, and some means by which milk can be preserved for a few hours until it is used. This latter, the writer claims, can be accomplished absolutely by boiling [or steaming. If then all the poor with whom we come in contact are urged to *boil* all the milk that they obtain from their milkman in the morning and place it in bottles tightly corked, the death-rate from "cholera infantum" would be greatly diminished. But a still greater service would be rendered to the poor if some of the larger and popular city dairies should sterilize, by steaming, a large quantity of their milk daily, should bottle it in six or eight-ounce nursing bottles, and tightly cork and sell these to the mothers in their neighborhood, at a price within their means.

As regards the sterilizing of milk for those in a better class of society, a sterilizing apparatus can be had in the house.—*Phil. Med. and. Surg. Rep.*, July 27, 1889.

THERAPEUTICS.

Pedigo (L. G.) on a Case of Veratrum Viride Poisoning; Use of Nitrite of Amyl; Recovery; Remarks.—On Friday evening, April 5th, at 7 o'clock, I was called in haste to see a child who was suffering from the effects of veratrum viride, occasioned by eating largely of the indigenous Indian or meadow poke root (American hellebore). It seemed that the patient, a boy of four years of age, had procured the root about noon, and, supposing it to be "artichoke," had eaten a large quantity of it about one o'clock. A small portion of it was vomited once or twice in the afternoon. According to the best history I could obtain, the vomiting had been very persistent and distressing for three hours; the strength had been steadily failing, and the extremities were growing colder each hour.

At the time of my visit, the patient was in a stupor; the hands and arms, feet and legs, were cold, the pulse exceedingly feeble, and the respiration shallow and somewhat irregular. When I succeeded with some difficulty in arousing him, the severe retching began at once. I administered a small dose of compound spirits of ether and French brandy, which was immediately rejected by the stomach, the patient falling back into the same condition of coma.

I then proceeded to use amyl nitrite by inhalation (as suggested by the writer in

the *Virginia Medical Monthly* in May, 1888). Three immediate results were noticed: the pulse was strengthened, the breathing became deeper and more satisfactory, and the patient awoke with a brighter facial expression then when aroused by other means. Whenever the sleep became at all profound, a few drops of the remedy were placed on a handkerchief and held to the nose, with the invariable effect of awakening the patient. Five minutes after the first use of this, the dose of French brandy and Hoffman's anodyne was repeated and retained. Fifteen minutes later a half glass of buttermilk was given—also retained. The amyl nitrite was used *pro re nata* for two hours. The extremities gradually became warmer, and the general condition of the patient was strikingly improved. He could sit up in bed without any return of the vomiting. In fact, this usually obstinate symptom never reappeared at any time after the use of the first drop of the remedy.

The patient was inclined to sleep lightly, when undisturbed, for about thirty-six hours. The recovery was steady, and in every way satisfactory.—*Va. Med. Mo.*, Sept., 1889.

Billroth on the Dangers of Carbolic Acid.—The following letter of Dr. Th. Billroth of Vienna has been published: "I have lately seen four cases, in which fingers which had suffered a most insignificant injury became gangrenous through the uncalled-for application of carbolic acid. Carbolic acid is now much less used in surgery than formerly; we have only gradually become acquainted with its dangers. The acid may not only cause inflammation and gangrene, but also blood poisoning, and so may even prove fatal. It is useful only in the hands of a skilful surgeon, and ought never to be used without his advice. The best lotion for recent injuries is the ordinary lead lotion, which can be bought at any chemist's. The best antidote in carbolic-acid poisoning is soap, which should be taken immediately and repeatedly until all symptoms of poisoning have disappeared."—*Lancet*, Aug. 31, 1889.

A Delicate Test for Lead in Water.—Add to one fluid ounce of suspected sample, contained in a porcelain dish, ten drops of a one-per-cent. solution of cochineal in proof spirit. The color is simply a dilution of the pink color if lead be absent, but one seven-hundred-thousandth part of lead will produce a purplish-pink tint, while one seventy-thousandth part gives a purple tint.—*Med. Press*, Aug. 28, 1889.

Ether as an Intoxicant.—The pernicious practice seems to prevail mainly in the north of Ireland, and statistics serve to prove that the lower classes take ether as a substitute for whisky to an alarming extent. Mr. Macartney informed the committee in the course of his speech that in the little town of Cookstown some traders sold as much as 20 gallons of ether per week; that one trader imported 120 gallons a week, and that 910 gallons passed through Belfast by rail every year for sale in Tyrone and Derry. Over four tons of the drug were sent by rail every year to Cookstown, Magherafelt, and Maghera; and the hon. member calculated that, inasmuch as half a glass sufficed to intoxicate an adult, the quantity thus known to be imported would account for 105,000 cases of drunkenness. He added the information that for the small sum of 6d. a man could get drunk on ether three times a day. But the figures given by the hon. gentleman admittedly failed to represent the extent of the traffic. A very large percentage of the trade is conducted with carts from Belfast, which supply the small shopkeepers, who in turn send the drug out to customers in their parcels of groceries.—*Med. Press*, Aug. 28, 1889.

Lime as a Disinfectant.—In the search after disinfectants, the efficacy of which if not always directly in proportion to the complexity of their chemical constitution, one seems to have lost sight of the valuable properties of substances at once cheaper and more accessible. Lime, for instance, has been shown to possess remarkable power in controlling the further development of the typhoid or cholera bacilli, and even two per cent. of lime in water is stated to be an effectual germicidal agent. Bacteriological experiments, conducted by different observers, have shown that a four-per-cent. solution of lime completely disinfects typhoid stools within half an hour, a result which was not obtained with either chloride of lime or corrosive sublimate. The best form to employ is the "milk of lime" prepared by slaking a kilogramme of freshly burned lime and then adding sufficient water to make up twenty per cent. This ought preferably to be recently made, its activity

diminishing after the lapse of a day or two. Only liquid stools admit of disinfection by this method, which has the advantage of being almost costless and devoid of an odor of its own. It has been proposed to use lime on a large scale for the disinfection of cesspools and sewers.—*Med. Press*, Aug. 14, 1889.

An Indian Supply of Podophyllum.—Dr. George Watt has, it appears, discovered that in the higher Himalayas the podophyllum plant grows in wild profusion, and what is of even more importance, it yields three times as much of the gum resin as the American root. Dr. Watt remarks that it is somewhat surprising that the natives of India, who have discovered so many drugs, should have failed to detect the medicinal properties of the podophyllum root. It is just possible, however, that more may be known about it among the hill tribes of Kulu than among those of the plains of India, and it may turn out that in those regions where the plant most abounds it has long been used as a medicine. At all events, the discovery is likely to provide the hill tribes of the higher Himalaya with a lucrative trade, and Europe with an abundant supply of the drug.—*Med. Press*, Aug. 21, 1889.

Wingrave (T.) on the Ill-Effects of Antipyrin.—A young lady aged twenty-one, has been under my care suffering from chronic ovaritis, associated with intense dysmenorrhœa. In addition to treatment by bromide of ammonium and tincture of gelseminum (which, by the way, were fairly successful in reducing the pain), I had given her some powders consisting of ten grains of antipyrin, one of which was to be taken when the paroxysms became severe. On July 25th last she took one of these (the first); about five minutes afterwards she experienced a very curious sense of heavy weight in the thorax, with a feeling of suffocation, her breathing became hurried and difficult, and there followed almost immediately a loss of power in the left side (the right side was slightly affected); in a few minutes a peculiar, very bright erythema appeared over the whole surface of the body, the patient appearing, as her mother said, "just like a boiled lobster." This rash was accompanied by a sensation of "pins-and-needles" down the left arm and leg; the circulation seemed to be arrested for a little while, as the rash faded to a dull purple. In a few minutes a feeling of collapse set in, accompanied by a profuse cold perspiration, and simultaneously severe vomiting began. In about ten minutes, under the influence of stimulants, all these unpleasant symptoms passed off, and she seemed to have recovered entirely. That the drug was good was shown by the fact that two or three other patients had had some quite recently from the same box, and I can only attribute the symptoms above described to an idiosyncrasy on the part of the patient. If such untoward attacks are to be reported frequently, it seems to me that the action of the drug should be more fully investigated experimentally than seems at present to be the case.—*Lancet*, Aug. 17, 1889.

The Narcotic Properties of Chloralamide.—Drs. Hagen and Häfter consider chloralamide one of the most reliable narcotics, and recommend that it should be given in a slightly acidulated solution or in wine. They say that the most appropriate cases for its administration are neurasthenia, spinal affections, and heart disease, and recommend a dose of fifty grains. The drug, when it acts at all, produces the desired sleep in half an hour. Its administration in phthisis has not proved so satisfactory, as in some cases it did not act at all, while in others, though sleep was induced, considerable general malaise was complained of on waking. They also gave it one morning to three convalescents from syphilis, who had taken a dose the night before with good effect. The result in all three cases was that the patients slept nearly the whole day, without being deprived of their ordinary sleep the next night. Before the communication of the authors to the *Münchener medicinische Wochenschrift*, experiments had been made altogether in twenty-eight cases (twenty-five patients and three healthy people), embracing 118 doses of the drug. A decidedly narcotic effect followed in twenty-six cases, superior to that of other narcotics in sixteen, and almost equal to it in ten cases. Complete failure occurred in two cases only—one of paralytic dementia and one of advanced phthisis; in a case of acute myelitis the result was doubtful. In comparing the amide with the hydrate of chloral, the authors decide in favor of the former, on account of its less unpleasant taste, and more particularly because its narcotic effect is decidedly greater than that of the hydrate. Undesirable effects

are certainly less marked and of less frequent occurrence with the amide than with the hydrate. They consist generally of slight headache and a somewhat dazed feeling on waking, but such symptoms occurred in only three of the twenty-eight cases; once collapse was noted, which, however, could not with any certainty be referred to the drug. Patients do not become accustomed to the amide of chloral, so that the same dose, however often administered, always has the same effect. The authors point out that the drug has not, as a rule, any specific effect on pain or other symptoms; but they mention a case of cardiac asthma in which the pulse, which had been very unsatisfactory, improved and maintained its improvement. —*Lancet*, Aug. 24, 1889.

Pollard (J. A.) on Glycerin in Dyspepsia.—In the *Medical Age* of February 11, 1889, I attempted to call the attention of the medical profession to the very great value of glycerin as a remedy in indigestion and dyspepsia. In addition to what I there said, I would like to make the claim in your journal that glycerin in drachm doses will be found most valuable in preventing stomach troubles in convalescence from debilitating diseases, that it will often cut short an attack of indigestion, and that it will *prevent* and *cure* a large proportion of cases of "summer diarrhœa" of children. It will also to a great extent control the vomiting of pregnancy.

I am most anxious to have these claims thoroughly tested. I am aware that new methods often appear to yield far better results in the hands of the originators than with those who subsequently use them. Therefore I request that every physician having cases of stomach weakness, acute or chronic, from whatever cause, summer diarrhœa, vomiting of pregnancy, etc., test this remedy and report results. It is simple, it is harmless, it is cheap, and it is efficient.—*Therap. Gaz.*, July 15, 1889.

McMechan (J. C.) on a Case of Chronic Cystitis Successfully Treated with Balsam Copaiba.—Annie A., aged eleven years, was sent to me for treatment on March the 7th, 1889. She had such distress in passing urine and suffered so much pain in the bladder that she had been unable to attend school for the past few years. I requested patient to furnish me a specimen of her urine. After letting it stand for twelve hours, a large amount of pus was found at the bottom of the glass.

From the severe pain, the distress in passing urine, and the large amount of pus present, a diagnosis of cystitis was made, and it was regarded as chronic owing to the above symptoms having been present for five years. The only remedy that had given any relief that had been prescribed was chloral, and this remedy was given freely to relieve the pain. It relieved the patient for the time being, but of course had no curative effect. Having treated other cases of chronic cystitis with marked success by the use of balsam copaiba, I resolved to try it in this case. Ten drops of the balsam were given four times a day in an emulsion and five drops of bi-meconate morphia were added to relieve the intense pain. After taking this remedy for a week the pus began to disappear from the urine, the pain ceased, and the patient was able to go to school again. At the end of a week the bi-meconate was left out of the prescription and the patient continued to improve without it. After treatment for a month the pus had almost disappeared from the urine, and after six weeks of treatment the patient considered herself well, although she intended to continue the balsam a little longer.

Balsam copaiba is one of our oldest and most reliable remedies for cystitis, and although it is a little out of fashion at present, yet it should always be given before resort is had to surgical interference.—*Cincin. Med. Jour.*, Aug. 15, 1889.

Marquis (M. V. C.) on Antipyrin in Cancer of the Cervix Uteri.—I have obtained favorable results by the use of antipyrin in a case of cancer of the cervix uteri, the pain being immediately subdued after its administration. Though this beneficial effect was of short duration, still it was of great importance and satisfaction to the patient. Being summoned to see a woman, apparently under forty years of age, I found her suffering from cancer of the cervix uteri in an advanced stage. She complained of severe lancinating pain, worse at nights, disturbing sleep, and of intense fœtor of the discharge, and of many other discomforts. She also stated that, having consulted several physicians, she had obtained no relief. The characteristic severity of the pain and fœtor of the discharge had reduced the patient to a pitiful condition. It occurred to me that anti-

pyrin perhaps would do her some good, so I prescribed ten grains of it to be given at once in my presence, aud great was my surprise, and still greater the satisfaction of the patient, to find the pain, which was so severe before, immediately subdued. Now I repeat the same when the pain comes on, and have observed no unpleasant symptoms arising attributable to antipyrin.—*Lancet*, Aug. 31, 1889.

MISCELLANY.

Dabney (W. C.) on the Mortality of Pneumonia in Malarial and Non-Malarial Districts.—I do not refer to the complication with intermittent or remittent fever, but to the death-rate from pneumonia in malarial and non-malarial districts, irrespective of any *apparent* complications with malarial disease in the former.

Conversation with physicians living in malarial regions has satisfied me that the mortality from pneumonia is far greater there than in sections of country where malarial affections do not prevail.

Possibly a study showing the prevalence of malarial affections and the death-rate of pneumonia at different times in the population supplying some of our large city hospitals with patients would throw light on this important subject.

In Piedmont, Virginia, where malaria does not prevail, pneumonia is considered one of the least dangerous of the acute febrile diseases, and it is rare to hear of a death from this disease, except in the aged or in those who have been habitually intemperate. On the other hand, I am told by physicians living in malarial sections of the State that pneumonia is one of the most fatal diseases with which they have to deal.—*Med. News*, Sept. 14, 1889.

Exhibitions of Hypnotism.—At Marseilles, Bordeaux, and Poitiers public exhibitions of hypnotism have been forbidden. Our Paris correspondent writes: The Departmental Council of Public Health advised the rector of the Academy to take this step in the districts under his authority, and he wisely followed the good advice. In Belgium, Geneva, and Mecklenburg-Schwerin, they are likewise forbidden. In Paris, unfortunately, unwise doctors can show off their patients, and quacks follow in their steps with unwholesome imitations.—*Br. Med. Jour.*, Aug. 17, 1889.

Bacteriological Study of the Kidney in Typhoid Fever.—Dr. Koniaeff publishes as a graduation thesis (St. Petersburg Dissertations, 1888–89, No. 13) an account of a series of observations made on patients suffering from typhoid fever at the Alexander Barrack Hospital, with the view of ascertaining the existence of typhoid bacilli in the kidney. It was found that "lymphoma" of the kidney occurred in 17 per cent. of the cases in which post-mortem examinations were made, and that typhoid bacilli were present in these centres of morbid change. In some cases bacilli were found in the urine, and it appeared probable that this was the only outlet for the bacilli in the kidney.—*Lancet*, Aug. 24, 1889.

Oliver (J.) on the Dysmenorrhœal Membrane.—Three years ago I suggested the adoption of the name "croupous endometritis," and for the following reasons:

1. Almost all the membranes of this character that I have examined have presented microscopically the appearances of an inflammatory exudation. The evolution of the membrane takes place, however, without any evidences of inflammatory disturbance.

2. Although pain is a symptom often complained of during the expulsion of such membranes, it is not an invariable accompaniment. In many of the cases under my own observation, these membranous casts of the uterus, sometimes quite entire, have been expelled without the aid of pain, so to speak, or without inducing pain.

3. Although the membrane is frequently separated from its underlying structure, in consequence of, and in association with, the menstrual excretion, it is nevertheless occasionally separated at other times as well. I have known complete casts of the uterus to be expelled without being either preceded or accompanied by hemorrhagic discharge. In such cases the ordinary every-day secretion taking place from the endometrium was sufficient to separate the adventitious structure. The phenomenon may occasionally represent an early abortion; that it, however, more usually results quite independently of a sexual congress I have no misgivings, as I have witnessed the expulsion of these membranes, not only in single women who were free from sus-

picion, but also in patients during their residence in hospital.—*Br. Med. Jour.*, Aug. 31, 1889.

Bird (F. D.) on the Occurrence of a Rigor Pyrexia and Erythema along the Distribution of a Nerve, the Result of Traumatic Irritation.—I removed an enlarged and tender gland from the left groin of a young male. It was the large one, which lies more superficial than the others, and proved to be riddled with minute abscess-points. In putting in the sutures, a deep silk one was adjusted in the upper part of the wound, in order to fill up the gap left. Shortly after this was tied, the patient, under the influence of chloroform, was suddenly seized with a well-marked rigor, which lasted about eight minutes; the anæsthetic was stopped, and after an interval the suturing was finished and a drainage-tube inserted. The patient looked blue and cold for the rest of the afternoon. It may be stated that he had never had ague. The next day he looked as if he were in for some serious illness. Dr. Maudsley's opinion inclined to some form of blood-poison, and mine to pneumonia. The temperature was 104° Fah. The tongue furred and very foul. No recurrence of the rigor. There was a slight cough and some headache. The wound presented nothing remarkable. There was some blood-stained discharge, no swelling, but a general diffused erythematous redness over the front of the belly and flank on the left side, extending over the crest of the ilium. There was no pain. The stitches were all removed, and the wound dressed with wet boracic wool. Five grains of calomel and an effervescing mixture were given, and further developments anxiously awaited. The following day the patient was much better. Temperature 100°. Tongue cleaner. No cough. The wound looked healthy, and the formerly diffused redness had dwindled down to two lines exactly marking the course of the two branches of the ilio-hypogastric nerve, the terminal trunk of whose hypogastric branch I must have included in my deep suture. The way in which eruptions follow the course of the cutaneous nerves is well known, as is the shock seen on the division of a large nerve or the spermatic cord, but the production of a rigor and a rash in the manner just related, I do not remember before. Granting that the constriction of the nerve by the suture was the cause of the symptoms, two questions arise: How is it that similar symptoms do not occur more frequently, for nerves of a similar character are constantly being surgically nipped (as in the operation of varicose veins); and again, What would have been the effect if the constriction had not been removed? After a good deal of reflection, the answer to the first of these does not occur to me; but with regard to the second, I firmly believe that great danger of tetanus would have ensued on the retention of the offending ligature.—*Australian Med. Jour.*, July 15, 1889.

Beall (E. G.) on Primary Wound-Treatment, with Especial Reference to Minor Railway Injuries.—A case that the author would suggest for preliminary dressings, intended not for the surgeon but for the use of the non-professional agent, conductor, or foreman who may chance to be in authority when the employé receives his injury, and before the services of the railway surgeon can be obtained, is as follows:

It should be of tin, not exceeding in size 6x6x12 inches, can be cheaply manufactured, and have printed instructions (pasted on inside of lid), so worded as to be readily understood by any one of ordinary intelligence. These cases (filled with emergency dressings), could be distributed or deposited with station agents, section or shop foremen, conductors, or others in authority, and be replenished from time to time as required.

Each case when filled should contain:

3 Yards of (Pink) Sublimate Gauze.
½ Doz. (7 grs.) Acidulated Tablets (colored *blue*) Bi-chloride of Mercury.
1 Drachm of Iodoform.
1 Yard of Oiled Paper.
2 Ozs. Bor., Salicyld., or Carbolized Cotton.
½ Doz. (3 yds.) 2½ Inch Crinoline Bandages.
½ " " " Muslin "
½ " Safety Pins.

The instructions on inside of case lid or cover should read something like the following: "As soon as possible after the infliction of the injury, wash the wounds thoroughly in about a pint of water (hot preferred) in which one of the blue tablets has been dissolved, and, after washing, dust over the wounded parts about ¼ of the yellow powder, and then apply over all so much of the pink gauze as may be necessary to completely cover from sight and atmosphere, and over this covering a layer

or wrapping of cotton. Then after thoroughly saturating in water one of the stiff (crinoline) bandages, squeeze the same and with it bind on by repeated layers the dressings thus far applied. Cover the whole with a single piece from the oiled paper, to exclude the air, and bind in place with one of the muslin bandages, fasten with a safety pin, and do not afterward disturb till the surgeon is reached."—*St. Louis Med. and Surg. Jour.*, Sept., 1889.

Reid (E. W.) on the Vital Condition of Various Absorbing Epithelia.—Dr. Reid claims to have gained evidence of the following facts in the case of the skin of the frog: 1. A definite absorptive force, apart from the force of osmosis, is exerted by the skin of the frog, comparable to the secretive force of the cells of glands. 2. This force is dependent upon the vital condition of the skin. 3. After removal of the skin from the circulation the absorptive force gradually diminishes, but may persist for three days when the skin is kept in normal saline solution. 4. Reagents tending to depress the vitality of protoplasm, such as chloroform, digitaline, and distilled water, diminish the strength of the absorptive force, while it can be increased by such a stimulant as alcohol in dilute solution. 5. In consequence of this force acting in a direction from without inwards, any alteration of the relation of the external surface of the skin to the denser of the two fluids employed in an ordinary osmosis experiment makes a difference in the rapidity of osmotic transference of fluid through the skin, according as the absorptive force is opposed to or in the same direction as the osmotic stream.—*Br. Med. Jour.*, Aug. 3, 1889.

Anæsthetic Whitlow.—In a certain number of cases of whitlow, sensation has been noticed to be absent or greatly impaired, and this absence of sensation was in many instances associated with muscular atrophy, limited, like the anæsthesia, to the upper extremities. A number of these cases is now on record, and they present many point of pathological and clinical interest. Dr. Thiriar, of Brussels, recently published the notes of a case of this kind which had come under his observation. The patient was a woman, sixty years of age, who six years before had sustained a severe crush of the thumb. This remained swollen and painful for years, and the swelling never entirely disappeared. Eighteen months before his attention was called to the case, the ring finger on the opposite side developed a whitlow, which burst spontaneously, and subsequently the thumb originally injured also suppurated. On examining the patient, whose general health appeared to be good, he was struck with the atrophied condition of the upper extremities and the absence of pain when he probed and manipulated the damaged fingers. There was complete anæsthesia on the back of the left arm and hand, and sensation on the left side was markedly diminished. Enlarged glands were noticed on both sides of the neck and along the anterior border of both axillæ. Basing his conclusion on the result of a post-mortem examination on a case recorded by Dr. Morvan, in which definite lesions were found of the peripheral nerves, and of the cords of the latter being limited to the cervical enlargement, Dr. Thiriar expresses the opinion that these cases of anæsthetic whitlow are due to degenerative changes in the nerve centres and nerves, which are themselves secondary to an ascending neuritis having for its *point de départ* a previous injury of long standing.—*Med. Press*, Sept. 4, 1889.

Conjugal Diabetes.—Dr. Debove read a note at the Société Médicale des Hôpitaux on the coexistence of diabetes in the husband and wife. Of fifty cases of diabetes, Dr. Debove observed five which existed simultaneously in the husband and in the wife. The same coincidence was established by Dr. Lecorché, who thought that this coincidence can only be explained in two ways: by the use of the same defective alimentation, or by the cares of life shared in common by husband and wife. Dr. Debove said that he could not accept this explanation, as women, from the nature of their habits and the exigencies of their sex, do not live exactly as their husbands. Hence it is that gouty couples are rare. He would therefore ask if diabetes were contagious; but for the present we must rest contented to register the fact. If new facts should show that conjugal diabetes is not a simple coincidence, it is only then one could propose a theory, which for the moment would be premature. Five or six other members also cited one or more cases in which they observed the coexistence of diabetes in the husband and wife.—*Lancet*, Aug. 24, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON M.D.

With the active collaboration of

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OCCASIONAL REPORT ON DISEASES OF THE EYE AND EAR.

BY A. T. MUZZY, M.D.

Jeaffreson (C. S.) on Retro-Ocular Abscesses of Both Eyes, Communicating through the Base of the Skull.—After a severe attack of scarlet-fever in a girl thirteen years old, symptoms of cerebral irritation appeared suddenly. A few days afterwards proptosis of both eyes was manifest, and sight was thought to have disappeared. On seeing her for first time at this juncture the ocular protrusion was well marked, with semi-dilated and inactive pupils. There was optic neuritis of both discs. The child was semi-conscious, and only answered in monosyllables when aroused. A deep incision was made on inner side of the globe, and forcing a director to the posterior wall of the right orbit, pus immediately escaped, and on making pressure over the left eye this flow of pus from the right was increased, showing communication between the two abscess cavities. A similar puncture was made on the left side to that on the right, pus escaping freely and in considerable quantities. In twenty-four hours urgent symptoms subsided, vision and consciousness returning, and in ten months restoration to health was complete, no trace of optic trouble remaining.—*Lancet*, July 20, 1889.

Swan (A. L.) on Foreign Body in the Eye for Two Years.—June 4th a thorn three-eighths of an inch in length was removed from the upper conjunctival cul-de-sac, where it had been for two years, causing only a very moderate amount of catarrhal conjunctivitis, but no sloughing of lid or sclera. The patient could give no history of injury, and had consulted medical aid once only during that time for the trouble.—*Lancet*, July 13, 1889.

Bennett (E. H.) on Melanotic Sarcoma of the Eye.—The case presented was remarkable for the slowness of growth, though its histological characters were decidedly malignant. Its character had been diagnosed eight years before at St. Mark's Hospital.—*Med. Press*, July 17, 1889.

Culver (C. M.) on Ocular Headache.—Nineteen or twenty authorities of the leading American, English, French, and German oculists describe this symptom due to faulty refractive conditions. Out of ten cases lately treated nine suffered from hypermetropic astigmatism. The tenth being simple myopia. And the wearing of the appropriate glass relieved the condition and symptom.—*Am. Jour. Ophth.*, June, 1889.

Turnbull (L.) on Furuncular Inflammation of the External Auditory Canal.—Mechanical irritation often produces this form of inflammation in the ear. A patient has been under treatment, suffering from four; one following the other in rapid succession. Seven years before the

same ear had suffered from severe traumatism, from which it had promptly recovered. The chief cause, however, of this affection is defective health from imperfect digestion and assimilation; in women, from irregular menstruation. The local treatment is disinfection by the use of sulphur, iodoform, and bichloride of mercury.—*Med. Register*, Dec. 24, 1888.

Green (J. Orne) on Malignant Disease of the Ear.—Diagnosis of malignancy in three recent cases of aural disease was made from the clinical history. No opportunity offered of making microscopical examination.

The general character of the progress of the disease consisted in pain with sanious discharge coming on in an ear previously suffering from chronic otorrhœa. Dark granulations intensely sensitive sprouted up from the tympanum, gradually followed by swelling of the mastoid region and also in front of the auricle. The swelling being hard and nodular, increasing steadily in size. Caries of the temporal bone began at an early date, attended with steady breaking down, the bone being very friable. Towards the close of the disease these swellings broke down at one or several points. Operations early in the disease relieve the pain, which when it returns is less sharp and constant than before, but is characterized as heavy and grinding. The length of the disease varied between eight and fourteen months. Removal of carious bone, cleansing, antisepsis, and drainage were chief in treatment. No glandular enlargements were found in these cases. —*Boston Med. and Surg. Jour.*, July 18, 1889.

Fulton (J. F.) on Railroad Injuries of the Eye.—Accidents happening to railroad employés, while following their vocation, are apt to be very severe. And my experience after many years is that many are lost for lack of proper and prompt treatment. The chief object is preventing suppuration. Antiseptics should, therefore, be used in cleansing the eye wounds and making them absolutely clean. This suppurative process begins very early. Instances are met where in twenty-four hours after penetrating wound of the vitreous, this chamber has been found converted into a pus sac.

The best treatment for punctured and lacerated wounds is syringing thoroughly the full extent of the wound with solution of bichloride of mercury 1–6,000 parts, by means of a lachrymal syringe or a Panas' anterior chamber syringe, removing as completely as possible every particle of foreign matter and blood clots. This can be done with perfect safety in any part of the eyeball. The proper treatment of the iris when it protrudes into the wound is a very important matter. Some say it makes no difference whether it is cut off or not. This is a grave mistake. If the iris after cleansing proves to have been also injured, the wound should be extended laterally, and the iris cut away from the vicinity of the wound to prevent danger of anterior synechiæ forming, or of its again being caught in the wound. If the iris has not been wounded, it may be safely returned to the anterior chamber. Penetrating wounds of the sclera often need stitching. This should include not alone the conjunctiva, but the scleral tissue as well. Removal of foreign bodies from the vitreous chamber requires the best of skill and patience. The indication for enucleation should be that of suppuration in the posterior chamber, or where it cannot be fully controlled. If a foreign body has remained for twenty-four or forty-eight hours without creating septic inflammation in the eye, no hurry should be allowed in removing it. As for traumatic cataracts, in most cases they should be allowed to remain until they become soft, when suction should be used for their removal. Some time should intervene between the accident and the operation. If from extensive laceration of the capsule, the lens matter swells rapidly, giving great pain, not an hour should delay the removal of the globe.—*Northwestern Lancet*, July 15, 1889.

Sexton (S.) on Autophonia.—From notes by Robert Barclay. This perception of one's own physiological processes of phonation, deglutition, respiration, circulation and mastication, is due to a disturbance in the equilibrium of tension in the transmitting mechanism of the ear. Sound reaches the auditory nerve by two courses by the air, and through the tissues of the neck and head. Phenomena of autophonia are met in nearly all diseases of the external and middle ear; and in those of the inner ear that disturb the auditory tension. Dislocation of the malleo-incudal joint and alteration in the tension of the membrana tympani are the two conditions that most frequently cause this phenomena. Audi-

tion by tissue conduction varies inversely to that by normal aërial transmission. In persons partially or totally deaf, who can hear their own voice, the mouth trumpet and acoustic fan are of service.

Catarrhal inflammation of the tympanum especially during the course of consumption or diabetes produces very characteristic forms of this symptom that are very distressing. They manifest themselves after a slight movement of the head, coughing, blowing the nose, yawning, swallowing, or eructation; these change the auditory tension and produce changes in audition.

Sometimes the subjective sounds prevent perception of external vibration, or so confuse them as to create mental distress more or less extreme. Prognosis under proper treatment is favorable.—*Med. Rec.*, May 9, 1889.

Fulton (J. F.) on Some Cases of Monocular Neuro-Retinitis. — While binocular neuro-retinitis is not uncommon, monocular neuro-retinitis without traumatic or neoplastic origin is extremely rare. The four cases presented show lack of a sufficient cause, acuteness in onset, and a disposition to respond favorably to treatment. The patients were enjoying good health and the eyes were not subjected to marked strain. Yet the symptoms had a definite, clear beginning. Vision being reduced to $\frac{5}{100}$ or 0. Resolution was steady and complete, and covered three to five weeks save in the first case, where the disk and the contiguous region towards the macula atrophied. Treatment consisted of leeches, iodide of potassium, inunctions of mercurial ointment and in two, hypodermics of pilocarpine.—*Arch. of Ophthal.*, N. Y., June, 1889.

THERAPEUTICS.

Therapeutical Novelties. — One hardly knows on what ground to pity our forefathers most, whether on account of the non-invention of bicycles, railways and other conveniences of locomotion, or the lack of anæsthetics and hypnotics. Little by little these wants have been fulfilled, until the number of hypnotics is almost equal to that of remedies for consumption. Each succeeding sleep-producer is asserted to be more perfect than its predecessors, and, if reports are to be believed, the more recent ones, far from being injurious, are positively conducive to health and good spirits. A practitioner who prescribes such an ancient drug as chloral hydrate runs the risk of being considered old-fashioned. Those veterans who adhere to the good old plan of dispensing their own medicines can, it is true, employ the drug, old or new, that pleases their fancy, and these are likely to make use of drugs with the effect of which experience has made them familiar, the more so, seeing that new remedies are, for a time, more expensive. No such considerations need weigh with the galloping prescriber. His prescription, which is sure to be closely scrutinized by the patient and his friends, now thoroughly *au courant* with pharmaceutical progress, thanks to the dissemination of pseudo-medical literature, must give evidence of his acquaintance with the latest derivative of coal tar, imported with the trade mark, "manufactured in Germany," or he will be looked upon as an old fogey not up to date. Pharmacy is getting to resemble the commerce in *articles de Paris*, of which the novelty is the most essential, if not the only feature. However confusing and unsatisfactory this plethora of therapeutical novelties may be, practitioners dare not fight against the current. Among the crowd are to be found remedies of undoubted value, and if one is to wait until their reputation has been formally consecrated by the Pharmacopœia Committee of the General Medical Council, many opportunities of affording relief to suffering, in cases hitherto refractory to treatment, will have been missed. If patients were only cognisant of the vast number of new drugs which are sent round to medical men, with a request that they may be "tried," a general feeling of uneasiness would certainly prevail, for on whom can the inquiring practitioner experiment if not upon those who look to him for relief. Fortunately, perhaps, the majority of medical men are decidedly conservative—some from indifference, some from sheer indisposition to the acquisition of further knowledge, and the result is that nine tenths of the samples forwarded for inspection are consigned to the dust-hole, whence they are exhumed later on by the rats, whose voracity is proverbial. The only way out of the dilemma would be the appointment of a standing committee of competent investigators, who should examine and report upon all claimants for admission

into the stomachs of confiding patients. We would venture to suggest that, with the funds at its disposal, the British Medical Association might very well endow such a committee, and insist upon all products passing through this ordeal before being allowed to figure in their advertisement columns.—*Med. Press*, Sept. 11, 1889.

Chloral Hydrate in Eclampsia.—Chloral hydrate is the obstetrician's sheet anchor in the grave disorders of eclampsia, but its administration is often a matter of great difficulty when the patient has lost consciousness. It can of course be given *per rectum*, but its retention is by no means easy to ensure, and its effects are correspondingly uncertain. It has been suggested to pour it through the nostrils of the patient by means of a funnel. With the patient in the dorsal decubitus the liquid readily finds its way into the pharynx, and excites the constrictors to act. Unfortunately it is by no means rare for the reflexes to be abolished or torpid even after a single crisis, and the liquid then finds its way down the larynx. Under these circumstances the only satisfactory way is to have recourse to the œsophageal tube, but before pouring the solution of chloral down it is desirable to ascertain that it has not gone out of its way into the larynx, as recently happened to a well-known foreign hospital physician. It is important to avoid administering solutions of the drug containing more than one part in forty of water, as otherwise troublesome vomiting is very likely to be set up. At the same time the drug should be pushed in proportion to the severity of the symptoms, two drachms being the medium, and half an ounce the maximum dose, in the twenty-four hours. It seems to exercise a specific effect on the production of eclamptic symptoms, and should be given in doses of from twenty to sixty grains daily in all cases of severe albuminuria associated with pregnancy.—*Med. Press*, Sept. 11, 1889.

Hollopeter (W. C.) on Phenacetine Poisoning.—Mrs. W., aged thirty, married, no children, slight, anæmic, of a nervous temperament, has been a great sufferer for years from a chronic pelvic trouble, an endometritis, and associated with it neuralgia of a most persistent character in the form of migraine or tic, in frequent paroxysms, occurring two or three times a week. Recently she had been on arsenic and iron and has greatly improved in general health. For her neuralgia she has taken antipyrin and antifebrin, and many other of the approved anti-neuralgic remedies.

Antipyrin and antifebrin she has taken frequently on different occasions in fifteen-grain doses four or five times daily, without any of the characteristic symptoms. She has not, however, received much benefit from their use. Last week I was hastily summoned to prescribe for her in one of her usually severe attacks. In recalling the previous inefficiency of antipyrin, I decided to give her phenacetine. Twelve powders each containing seven and a half grains were given, a powder to be taken every two or three hours. Six hours after leaving my patient I was again urgently requested to see her, and found her in a state of collapse, severe præcordial pains, and great dyspnœa, lividity of the whole surface, nails, lips, and conjunctiva; great restlessness, inability to lie down or stand; was supported in a semi-recumbent position. Temperature at the time of my first visit was 101½° F. Involuntary movement of the bowels occurred once; pulse below normal, slow and soft; cold perspiration; pupils slightly dilated. She remained in this condition for about ten hours, slowly improving under the use of ammonia and alcoholic stimulation. The blueness did not fade for more than three days. Convalescence was very slow, the patient not being able to be around her room for over a week. Three powders of seven and a half grains each were taken during the six hours.

While I regard phenacetine as the most reliable remedy we have for any nerve pain, never requiring it in larger doses than two or three grains, frequently repeated, if necessary, the apparent tolerance of the patient for the drugs antipyrin and antifebrin was strikingly offset by the use of phenacetine.—*Med. News*, Sept. 21, 1889.

Murray (G. R.) on the Physiological Action and Therapeutical Value of Apocynum Cannabinum. — The author is convinced that apocynum is useless in dropsy unless it is of a cardiac origin, acting thus as a cardiac tonic. He asserts that the diuretic action of the drug ceases as soon as the dropsical fluid has been run off. It has the disadvantage of sometimes causing persistent vomiting and aggravating a diarrhœa. The preparation

employed was the tincture in from 10–20-minim doses.—*Therap. Gaz.*, Sept. 16, 1889.

Foote (C. J.) on the Sterilization of Fæces.—The best disinfectants to use are the bichloride with hydrochloric acid, the bichloride with potassium permanganate, and the chloride of lime.

Five per cent. solutions of carbolic acid and two tenths per cent. solutions of the bichloride are unreliable even when used in the proportion of one pint to every 100 c.c. of dejection.

Emphasis needs to be laid on the necessity of thorough disintegration of the fæcal matter by stirring with the disinfectant, and on the necessity of allowing the mixture to stand four hours at least before emptying.

For continued use the bichloride solutions would injure lead pipe, while if used for a few days only probably no injury would result. For long-continued use, where the dejections are thrown into a water-closet, chloride of lime is undoubtedly the most available disinfectant.

Solutions of chloride of lime should be kept tightly corked and should not be used after they are one week old.—*Am. Jr. Med. Sci.*, Oct., 1889.

Wilding (J.) on the Toxic Effects of Ten Grains of Antifebrin.—The patient was a young man, aged 19, suffering from acute pulmonary tuberculosis, of about a month's duration. His temperature during that time had varied between 101° and 104° F., in spite of the successive use of antipyrin, aconite, antimony, and quinine. Antifebrin was then tried. A dose of ten grains in milk was given on May 31st, at 2 P.M. In fifteen minutes the patient was all of a glow. In half an hour he was excessively red over the whole body and perspiring profusely. At 3 P.M. the temperature had fallen from 103.1° to 98.3° F. He then complained of feeling cold and numb in the legs and feet, and began to shiver. The coldness spread up the trunk, the redness of the body disappeared, with the exception of a slight hectic flush on the cheeks, but the sweating continued. At 4.30 P.M. the patient was semi-conscious, deathly pale, and cold, but still sweating, and the temperature in axilla was 97° F. At 6 P.M. I found the patient semi-conscious, pale, and cold. Heart-sounds feeble, and pulse could just be felt at the wrist. Pupils dilated; respiration shallow, and of a sighing character. The thermometer in mouth and axilla would not rise above 95°. At 6.30 the patient was at his worst and apparently moribund, and the pulse could not be felt at wrist. Warm brandy with ammonia and digitalis was administered by mouth. Hot bricks were applied to soles of feet, calves, spine, and axilla, with mustard poultice over the heart. In an hour's time the surface of the body had become warmer, pupils contracted to light, respirations and heart-sounds stronger, and pulse could be felt at wrist; but the thermometer would not rise above 95°. The treatment was continued through the night, and at 4 A.M. the next morning the thermometer registered 96.2° in the axilla; at 8 A.M. it was normal; at 11 A.M., 100.4°, and all symptoms of collapse had disappeared. The patient could recollect nothing of what had happened, and was apparently none the worse. Three days later, two grains of antifebrin were tried with a similar, though very much slighter, result. The patient lived fifteen days longer, with an average temperature of 102.6° F.—*Br. Med. Jour.*, Sept. 14, 1889.

Alcoholism.—For some time alcoholism has been engaging the attention of alienists, who attribute to it much of the increase of insanity. During the last fifty years, states a report submitted to the Minister of the Interior, the consumption of alcohol has trebled, and the number of lunatics has quadrupled. Crime and suicide are also steadily on the increase. In the years 1872–87 the number of suicides have increased by 55 per cent. Their proportion in regard to the population has risen from 15 to 21 per 100,000 inhabitants. Women resort less frequently to suicide than men. As shown in previous statistics, the frequency of suicide bears a relative proportion to age. Thus up to the age of forty years the propensity to suicide remains the same in women as in men, but after this period it increases regularly with age. The report of the last International Congress for the Suppression of Alcoholism, which was held in Paris from July 29th to August 1st, 1889, contains the old and familiar statement that criminality and mental aberration follow a march parallel with the consumption of alcoholic beverages. It is also stated that the number of crimes and offences against morals is exactly in ratio with the consumption of alcohol. To the influence of the excessive use of alcohol is also attributed the degradation

of the race, it being a fact that the health of children almost always suffers from the alcoholic excesses of the parents. To the same influence is attributed in part the phenomenon of the continued diminution in the population of France, more noticeable in some parts than in others, for in the wine-growing districts drunkenness is less prevalent than in those where the consumption of alcohol is relatively considerable.—*Lancet*, Sept. 14, 1889.

Richardson (C. W.) on an Interesting Toxic Manifestation of Cocaine.—To facilitate the removal of a cartilaginous spur from the nasal septum of a healthy woman the author injected into the tissues a solution containing about one grain of cocaine. Most remarkable and decided evidences of erotic excitement appeared, which necessitated a postponement of the operation. The woman expected to be unwell the next day. A few days later the local application of a small amount of the drug in solution produced similar but slighter effects, but the operation was performed. No effects disagreeable to the patient were experienced.—*Jr. Am. Med. Assn.*, Sept. 7, 1889.

Kreider, (G. N.) on the Treatment of Pneumonia by Tepid Baths.—The conclusions of the author are: 1. They should only be given in those cases which are not progressing favorably. 2. In severe cases nothing is calculated to give so much relief to all bad symptoms. They shorten the duration of the disease and of convalescence, and reduce the mortality. Liebermeister says it has been reduced in his hands from twenty-five to ten per cent. 3. Rules for selecting cases and administering baths cannot be rigidly given. The thermometer is not always the guide for their administration. Difficulty of respiration and lack of secretion should lead to their employment, regardless of the height of the mercury. 4. The temperature of the bath should be one hundred degrees or less, depending on the severity of the case and the condition of the patient. Baths of extremely low temperature I have not found necessary as yet, but should not hesitate to employ them if occasion should require. 5. Stimulants should be given just before entering and on coming out of the bath-tub. The patient should not exert himself in the least. 6. The physician should himself superintend and aid in giving the bath. This rule could only be broken by having trained nurses who are competent to meet the emergencies which might arise.—*Med. Record.*, Sept. 7, 1889.

Death from Suspension.—Another case of death has occurred from the suspension treatment of locomotor ataxy—this time in Italy. The case, which is reported in the *Riforma Medica* of July 19th, occurred in the clinic of Professor E. Galvagni.—*Med. News*, Sept. 7, 1889.

Potter (T.) on Artificial Anæsthesia during Sleep.—I was called at 9 P.M. on July 2d to see a case of injury to the arm. The patient was a boy, aged eight, rather delicate in appearance, timid, and of slight build, but whose general health was good. The injury had occurred nearly two hours previously, and the swelling and extreme pain prevented a thorough examination without an anæsthetic, which being given, fracture of the lower end of the humerus was found, the internal epicondyle being broken off.

Seven weeks before this the boy had received a severe scalp-wound, during the suturing of which chloroform was given. This was a short time after a meal; he vomited freely during and after the use of the anæsthetic, and was sick for some hours. He was therefore now much frightened over, and dreaded, the idea of having to take "that nasty stuff again."

Adjusting the arm in a comfortable position, I left him for about half an hour. When I returned with Dr. J. W. Marsee, of this city, he was sound asleep.

At the solicitation of his family I made the attempt of giving the anæsthetic without waking him. The experiment was completely successful. The patient passed directly from sleep into the artificial anæsthesia, the only signs of irritation being a slight holding of the breath, and a few side-to-side movements of the head just before complete anæsthesia was reached.

The dressing lasted twenty minutes; the anæsthetic was then withdrawn, the patient passing into natural, quiet sleep, without the slightest sign of disturbance. He did not vomit during or after the chloroform, and experienced no perceptible ill effects from it. Three and one half hours afterward, at 2 A.M., he awoke, not having any knowledge of what had occurred, and expressed surprise that his arm had been dressed.

The anæsthetic used was chloroform. It was given on a small, thin handkerchief,

gradually at first, and with very free admixture of air, near an open window, and was as gradually withdrawn. The quantity used was exactly three and one half drachms. The supervention of complete anæsthesia was quite sharply marked by the change to regular, deep, easy breathing, and full relaxation following slight rigidity of the muscles of the face and chest.

A plaster dressing was applied, completely immobilizing the arm; there was thus the least possible irritation remaining after the withdrawal of the chloroform.—*Med. Record*, Sept. 7, 1889.

MEDICINE AND PATHOLOGY.

Microbes in the Mouth of a Healthy Person.—As the finding of these microscopical animalculi forms a very important feature in our diagnosis, it is necessary to guard against the danger of fallacies to which this form of examination is open. It is not surprising to find such micro-organisms in the mouth when it is considered how few of us escape with sound teeth, or are entirely free from some form of stomatitis. Netter has just completed a lengthy inquiry on the subject, in which he tells us that in 20 per cent. of the cases of healthy persons examined he found Fränkl's pneumonia cocci, in five-and-a-half cases the streptococci, and four-and-a-half Friedländer's capsulated bacilli. Now the pneumo-coccus, though its name suggests, is not the only disease in which this micro-organism is found, as it is common to broncho-pneumonia, endocarditis, meningitis, etc., while the streptococcus is not yet limited. The mouth he considers a favorable locality for cultivating the microbe, owing to the reaction of the saliva being slightly alkaline and favorable to its development. When this canal has been kept in a state of alkalinity for a long time the microbe will flourish, but if the gastric juices become too acid the microbe is destroyed. Breathing and feeding favor this region for their cultivation, and Netter does not allay our fears when he tells us that a child in early life develops these in the mouth, whence they pass by the Eustachian tube to the ear and set up otitis, or may be the origin of meningitis by passing to the coverings of the brain by the middle ear. If the breathing tract be healthy the germ may be resisted, but if accidents of cold or abrasions take place the germ becomes dangerous. In this way he accounts for the attacks of definite diseases, as measles, scarlet-fever, diphtheria, etc., which are only secondary infections. Another suggests that the virility of the germ will depend much on a few unknown factors as the variability of the microbe or its activity, and the meteorological changes which may greatly modify its action. One practical hint may be derived from his labor, that we should always keep the mouth disinfected, in order to protect the other orifices leading out of it.—*Med. Press*, Sept. 4, 1889.

Diphtheria Conveyed by Cats.—Dr. Lawrence, of Halstead, Ks., writes that last winter he was called to attend a little three-year-old girl suffering with diphtheria. Upon careful inquiry it was found that she had not been exposed to the disease, although there were some cases within a mile of her father's house. He incidentally learned that there was a sick cat in the house, which had been fondled by the little girl some days before. The cat died shortly after its playmate became sick, and a second cat also became sick and was killed. Suspicions were aroused that the disease was conveyed by the cat, and inquiry revealed the fact that one neighbor farmer had lost seventeen cats, and another fifteen, with some throat trouble. One of the farmers stated that he had examined the throats of some of the cats, and found them covered with a white membrane. The little girl died, and her little brother a few days later had a severe attack of the same disease. Cats are disposed to run from house to house at night, and one diseased cat may be the means of carrying diphtheria to half the cats in a neighborhood, they in turn carrying it to the children whom the parents are taking every means to protect from danger. It is well to keep an eye on the cats in times of diphtheria.—*Med. Age*, Sept. 10, 1889.

Tattoo Maladies.—A number of cases have been placed on record within the last few years in which the syphilitic infection was conveyed from the condylomatous mouth of the operator into the system of his victims, and now we are asked to believe that tuberculosis also may be conveyed in the same manner. The case is reported by Dr. Fournier, of Lyons. In July, 1887, the patient was tattooed with

Indian ink mixed with saliva. The operation was followed by an eruption of little vesicles on the site, succeeded by intractable ulceration. In January, 1889, a warty scrofulide was found on the back of the hand, and there was a small abscess on the front of the forearm. Bacteriological examination of the tissue failed to afford any evidence in support of the diagnosis, which, however, was confirmed by the subsequent history of the case. Under the lactic-acid treatment the general condition of the patient improved, although his expectoration contained swarms of bacilli.—*Med. Press*, Sept. 11, 1889.

Whitehead (H. R.) on an Outbreak of Syphilis following Tattooing.—The tattooer, Private O., of the Lincolnshire Regiment, had obtained a great name as a skilful and artistic performer, and between January, 1887, and July, 1887, as far as we could ascertain, he had tattooed about a dozen men; of these, five developed syphilis, the rest of the men were inspected and found healthy.

Private O.'s history was as follows: He was admitted to hospital November 19th, 1886, with a hard chancre on the penis, had roseolar eruption and sore throat in the middle of December, 1886, and when he came under observation in July, 1887, he had ulceration of his throat and tongue, loss of hair, psoriasis, and mucous patches on his tongue and gums. He stated that he tried to avoid drawing blood while tattooing, which process he effected by needles; if he drew blood, he washed it off with water; if the latter was not handy, he used the saliva for this purpose. In all cases in which syphilis followed the process he had used his saliva to clean the surface.

1. In none of these cases was the sore multiple, nor were there any of the sores rupial in character, being in each case of the true Hunterian variety. 2. Marked induration of the brachial and axillary glands accompanied each case. 3. The copper-colored discoloration and induration at the seat of the primary sore continued for a long time. 4. None of the cases had suffered from syphilis previously. 5. The case in which epilepsy was present before syphilitic inoculation occurred is interesting from the fact that the primary disease (epilepsy) was much aggravated by the syphilitic poison. 6. All these cases were treated with mercury and iodide of potassium. In each case great debility followed the disease, but most of the cases had suffered in a more or less degree from ague previously, and had been sent up to Landour for their health. 7. The incuba-

TABULAR RETURN OF CASES OF SYPHILIS FOLLOWING TATTOOING.

Case.	Date of Tattooing.	Date of Appearance of Primary Sore.	Part Affected.	Date of Appearance and Character of Secondary Symptoms.	Remarks.
1. Private C., Lincoln Regiment	February 1, 1887	About February 21	Left forearm	Beginning of March had sore-throat and roseolar eruption. End of May suffered from ulceration of throat and fauces; had also at this time syphilitic retinitis very severe. Became quite bald, and become very cachectic.	States that Private O. only used his saliva to clear the surface at one place; the chancre appeared at that spot.
2. Corpl. W., Lincoln Regiment	March 14, 1887	March 25	Left forearm	Did not notice any sore throat or roseolar eruption till the end of April. At the end of May suffered from syphilitic ulceration of rectum. Glands of axilla and elbow much indurated.	This man had epilepsy previous to syphilis. Fits became very frequent while suffering from syphilitic poison.
3. Private R., Lincoln Regiment	April 20, 1887	End of April	Left forearm	Sore-throat and roseolar eruption beginning of May; began to lose hair end of May. In August had ulceration of throat and copper-colored eruption on abdomen.	States that Private O. used his saliva to clean surface, and that sore appeared on first spot tattooed.
4. Private P., K.O.S.B.	April 21, 1887	Between four and five weeks after	Right forearm	Sore-throat and roseolar eruption six weeks after tattooing. Three months from date of tattooing ulceration of throat; loss of hair and copper-colored eruption on body.	Sore first appeared as a small pimple at the spot where the operation commenced. Private O. used his saliva to clean surface.
5. Private S., Lincoln Regiment	June 10-15, 1887	June 22	Left forearm	Did not notice sore-throat or roseolar eruption. Hair began to fall out middle of August. Ulceration of throat and gumma on tongue middle of September, accompanied by copper-colored eruption on body.	Seat of chancre first place pricked. Remembers Private O. using his saliva to clean the surface.

tion stage was short in all the cases. 8. The sores appeared invariably at the first point pricked.—*Br. Med. Jour*, Sept. 14, 1889.

Bernardy (E. P.) on Suppression of Urine for Seven Days in a Child Two Years Old without Serious Result.—The case seems to me to be one of idiopathic suppression of urine. No assignable cause could be found, the little patient had enjoyed good health up to the time of its illness; never had measles, scarlet-fever; in fact, none of the diseases of children; had an attack of catarrhal pneumonia when eight months old. I was requested to see the little patient on the evening of August 17, 1888. He had been ailing for the past few days, disinclined to play; when well of a lively disposition. Nausea was present, and vomiting had occurred during the day; tendency to loose stools; tongue clear, white, and flabby; skin white, eyes dull, pulse quick, no fever; ordered pepsine mixture. The next day, stomach more irritable, could not retain any thing, had an attack of hiccough, pulse full and quick, no fever; was informed by the mother that the child had not passed any urine since the evening of August 10, 1888; ordered xx gtts. spt. ether. nit. in warm water every hour or two. The following day (August 19, 1888), condition about the same. Passed about a quarter of a teaspoonful of pure blood from the penis. Examination over region of bladder showed no indication of fluid. Ordered a warm digitalis and flaxseed poultice to be applied over region of kidneys; a bitart. potassa mixture, with infusion digitalis, internally. August 20th: No improvement. Did not sleep well during the night, eyes dull, twitchy movement of the muscles of the upper and lower extremities, easily started. August 21st: Twitching increased, face of waxy hue, skin hot and dry, bowels opened several times. August 22d and 23d: Skin burning hot, restless, sleepless, twitching excessive, head thrown back, eyes dull and heavy, face puffed, skin waxy, lips bloodless, no pain locally, even when pressure is made. August 24th: Close examination over region of bladder shows it empty; six dry cups over kidneys and other treatment continued. Five hours later passed a large quantity of clear urine. August 25th: All nervous symptoms abating, eyes clear, stomach less irritable, passed urine of a light yellow color. Improvement continued, and patient discharged September 5, 1888.—*Weekly Med. Rev.*, Aug. 3, 1889.

O'Neill (W.) on Hair Passed in the Urine.—On May 5, 1887, I was consulted by Mr. A. for disease of the bladder, one very remarkable feature of the complaint being that he passed hair in the urine. The patient was fifty years of age, rather short and stout, and regular and temperate in his habits. Twelve months before he called upon me he began to suffer from irritability of the bladder; three months after this he noticed blood in his urine, and about five months subsequently to the hemorrhage he discovered hairs in that fluid. The hairs at the outset were single, and not very numerous; but as time went on they increased in number, and some of them formed little tufts. The patient sometimes felt a sense of weight and uneasiness in the region of the bladder, but he did not seem to have suffered much pain, excepting occasionally when in the acts of micturition the flow of urine was interrupted by clots of blood. The hemorrhage from its commencement recurred every five or six weeks, but the bleeding was not very profuse at any time. In the attack preceding his calling upon me, he thought, however, that he had lost more blood than on any other previous occasion; nevertheless, he was still a ruddy faced, healthy-looking man. He had declined in weight, but this he accounted for by recently defective appetite, and from being frequently disturbed in the night by the irritability of the bladder. The patient's urine was abundant, averaging about four quarts a day, but then he indulged in copious draughts of milk, to which he was rather partial. The specific gravity of the urine ranged from eight to ten degrees; the reaction of the urine inclined to alkalinity, and when free from blood it contained merely a trace of albumen, but no renal casts, mucus, or pus. Floating in the urine, or lying on the bottom of the chamber-vessel, now and again could be seen particles of matter which the patient called "skins," and which to my unassisted eye looked like little bits of coagulated albumen or fibrin stained more or less with blood. Also in the urine at all times could be seen hairs, more or less numerous, of various shades of dark and light color, and varying in length from half an inch to two inches and a half, and I have seen a few hairs not less than four or five inches in length, which he assured me

he had drawn out of the urethra. On looking at some of the ordinary hairs that I chanced to have preserved, I find the majority of them are light in color, and that the thick and thin ends are well marked, even in the most downy specimens. When the urine contained blood, the hairs assisted in forming little clots, which the patient had sometimes difficulty in voiding; indeed, it was this fact that first drew his attention to the hair. As might be supposed, some specimens of urine contained more hair than others. On one occasion I fished out of a chamber-vessel not quite full of urine a small ball of hair. The patient, who was a clever man, frequently looked at the hairs through a microscope, and was familiar with their appearances and peculiarities. I have had the urine microscopically examined by two young medical men, who in addition to the hair only found some blood-corpuscles, epithelial scales, and on one occasion pus cells. To prevent any extraneous matter finding its way into the urine I ordered the chamber-vessels to be always washed with pure water before the patient passed urine into them, and to be kept closely covered till examination took place. In the carrying out of these commands it was not an uncommon thing to see a row of six or eight vessels arranged along the wall of the patient's bedroom; the arrangement frequently excited a little mirth in some of his relatives, who could not see any use for "such a display of crockery."

I may say that with the exception of the bladder complaint Mr. A. considered himself in fairly good health. His pulse was regular, his heart and lungs were sound, and there was little or no increase of temterature. On account of the hæmaturia he was ordered gallic acid and hamamelis virginica, and when the hemorrhage was subdued he took nitric acid, buchu, uva ursi, and strychnine. In this way he went on slightly improving until the sultry weather of August, when he was attacked by most violent diarrhœa and vomiting, and whilst in this state he was suddenly seized with apoplexy, which carried him off in a day or two. I was told that the patient's family is peculiarly susceptible to bowel affections, which in its members generally assume a grave character, for two of his sisters and a brother had died of intestinal diseases of some kind. No autopsy was obtained.—*Lancet*, Sept. 14, 1889.

Diabetes Mellitus after Extirpation of the Pancreas.—Drs. V. Mering and O. Minkowski report a large number of experiments from their laboratory at Strasburg, all showing that extirpation of the pancreas results in true diabetes mellitus with all its ordinary symptoms. A dog whose pancreas had been removed secreted after forty-eight hours' fasting from 5 to 6 per cent. of sugar in his urine. Another dog weighing 15 lb. secreted under an exclusive meat diet two pints of urine daily, with 6 to 8 per cent. of sugar. Introduction of grape sugar into the food resulted in an increase of this by 6 per cent., by far the greatest part of the grape sugar being excreted without having undergone any modification. The urine also contained appreciable quantities of "acetone." The percentage of sugar in the blood was likewise much increased, being in one case 0.30, in another 0.46. Glycogen at the same time disappeared altogether. In a dog, for instance, which had been diabetic for four weeks, and which was killed while being fed on full flesh diet, neither liver nor muscle contained glycogen. Transfusion from a diabetic dog caused no secretion of sugar in a healthy dog.—*Lancet*, Sept. 14, 1889.

A Case of Actinomycosis.—A case of actinomycosis had recently been under the care of Drs. Kneer and Conrad, of New York. The patient, a German machinist, began to complain of pain and soreness in the right hepatic region in February last. The trouble having continued for some time without relief, exploration was determined upon, and this showed the presence of pus, which under the microscope was found to contain the actinomyces in abundance. One characteristic feature of the symptoms was a continuous high temperature. Injections first of boracic acid and afterwards of bichloride of mercury (1 to 2,000), were made from time to time, in the hopes of interfering with the growth of the fungi, and the bichloride seemed to have the effect of bringing down the temperature considerably. Finally, however, pyæmia set in and the patient was carried off by an attack of pneumonia. At the autopsy the destructive effects of the fungus were found to be well-marked. The actinomyces appeared to have first attacked the intestinal canal and then the liver, which weighed nine and one half pounds, and was studded with myriads of

them. The greater part of the left lobe was in a gangrenous condition.—*Boston Med. and Surg. Jour.*, Aug. 15, 1889.

Maggots in the Ear.—J. Holmes, M.D., writes to the *British Med. Jour.*, Aug. 3, 1889: A man, 66, with a history of middle-ear disease from infancy, and who had been totally deaf in left ear since that time, came July 24th complaining of "maggots in the ear." He said that whilst haymaking about 2 P.M. on July 23d, a small blow-fly settled in his ear and remained there for about ten minutes in spite of his repeated endeavors to dislodge it. About 2 A.M. on July 24th he felt a stabbing pain in his ear, and there was a slight discharge of blood. He inserted some fresh cotton-wool in his ear, and on subsequently removing this found one or two small maggots. He came to the surgery at mid-day on the same day, and on removing the wool from the ear there was a small maggot on it, and two observed crawling on his neck. His ear was syringed, and one or two came away. He was told to drop some sweet oil into his ear. He returned on the morning of July 25th, and his ear was syringed with a weak antiseptic solution, and one larger one came away. He then stated that about forty had come away altogether. He returned in the evening feeling much more comfortable, and believes there are no more there. They had the appearance of ordinary maggots, such as one sees in fly-blown meat, and were from about a quarter to half an inch in length.

Abbott (G. E.) on an Obstetrical Eye-Bandage.—During the average confinement, at the end of the second stage of labor, while the accoucher is busy tying the cord and afterward (with the assistance of the nurse) is attending to the safe and neat completion of the third stage, the baby is busily engaged in inoculating his eyes with cultures of vernix cascosa, etc., and often has such success that, like many another scientist, he, in due time, becomes blind to every thing else, but by no means dumb.

To prevent this result I have of late practised as follows: As soon as the child is born, and while I am waiting for the pulsations in the cord to cease, I give the care of the uterus to the nurse and carefully cleanse the face of the baby with damp aseptic cloths, and place over the eyes a narrow bandage (about two inches wide and a yard long), also damp and aseptic, and secure it with a safety-pin, then cleanse the baby's hands, tie the cord, wrap the child in flannel, protected by a diaper, and let it care for itself with perfect safety, until the nurse is ready to wash it.

Thus far I have had no ophthalmia neonatorum.

Of course this will not prevent all ophthalmia, especially those catarrhal forms due to bright light, cold, smoke, dust, and gases, from ill ventilation; but by its use, those severe and distressing blennorrhœal forms of gonorrhœal, septic, and puerperal infection will, I believe, be largely prevented.—*Med. Record*, Sept. 21, 1889.

Young Parents!—An anonymous writer reports a case that came under his observation before he commenced the study of medicine, in which the mother was hardly thirteen years old, and the father was a little less than fifteen. The child was born at full term and lived about four months.—*Daniels' Texas. Med. Jour.*, August, 1889.

SURGERY.

Hare (H. A.) on the Effect of the Entrance of Air into the Circulation.—From experimentation on dogs the author concludes:

1. Death never occurs from the entrance of air into the ordinary veins of the body unless the quantity be enormous,—from one to several pints, a quantity which cannot enter unless deliberately sent in by the surgeon.

2. The cases on record have been due to other causes than air and have not been proved.

3. The tendency of the vessel to collapse and the leakage of blood prevent any entrance of air, and it would seem probable that a clot has generally caused death, not the air itself.

Seventy dogs in all were used. The dogs were of all ages, sizes, breeds and states of health. The amount of air injected into the jugular vein varied from a minute bubble to 40. c. c.

Injection of a small amount of air into a carotid artery almost invariably caused speedy death with convulsions and paralysis.—*Therap. Gaz.*, Sept. 16, 1889.

Nitrogenous Contents of Sputum.—Dr. M. Panoff has examined the sputum of

patients suffering from various forms of lung disease with the view of ascertaining the amount of nitrogen expectorated. The details of his results are given in No. 2 of the St. Petersburg Dissertations for the session of 1888–89. The estimations, which of course included both the liquid and precipitated portions of the sputum, were made by means of the Kjeldahl-Borodin process, the general result being that the greatest daily expectoration of nitrogen was 1.14 gramme, and that the sputum which contained the largest amount of nitrogen, both when reckoned by the total daily expectoration as well as by its percentage composition, was that of phthisical patients, while, on the other hand, that which contained the least nitrogen, both absolute and relative, was that occurring in cases of bronchitis and croupous pneumonia.—*Lancet*, Aug 17, 1889.

BOOK NOTICES.

Swedish Movement and Massage Treatment.—By Hartwig Nissen. With twenty-nine woodcuts. 8vo, pp. 128. F. A. Davis, Philadelphia, 1889.

This is a very small volume which may well serve the general practitioner as a hand-book and guide to treatment by this therapeutic system. It is written in an explicit style, and this, together with the illustrations, render the subject so clear that the little book may also prove useful as a text-book in training-schools for nurses. Chapter IV., which treats of the application of the method to various diseases, is open to considerable criticism because of its vagueness and its exaggerated statements. Were it not for its value as indicating the character of movements to be employed in different diseases, this chapter might better have been left out. But upon the whole we take pleasure in commending the book to the profession. F. P.

Inebriety: its Etiology, Pathology, Treatment, and Jurisprudence. By Norman Kerr, M.D., F.L.S. Second edition. 8vo, pp. 471. H. K. Lewis, London, 1889.

The subject of inebriety has been discussed very largely of late. Dr. Kerr, we believe, was one of the first to promulgate the idea that it is a disease as amenable to treatment as most other diseases. His first lectures were delivered thirty years ago in England and the United States. This volume, containing the results of his thought and experience of over a quarter of a century, was published only a year ago, and the appearance of a second edition in so short a time is a just tribute to its general excellence and popularity. The author is gifted with an unusual beauty of diction, which renders any subject upon which he writes readable and entertaining, even though we may differ from him in many points taken up by him as an enthusiastic inebriety specialist. There is not space for an extended review of his work here, but some general idea of the contents of the volume may be derived from a perusal of chapter headings. The first and second discuss inebriety as a disease allied to insanity; the five following chapters describe the various forms of inebriety; then are added four on the etiology, two on the pathology, five on the treatment, and, finally, five chapters on the medical jurisprudence of the disease. Under the head of forms of inebriety the following are defined and discussed: periodical, habitual, social, solitary, neurolytic, and those corresponding to various inebriating agents, like alcohol, chloral, chloroform, ether, chlorodyne, cocaine, gelsemium, sumbul, lavender, etc.

Since the first edition of this book appeared, the British legislature has enacted permanent laws with regard to inebriates, embodying improvements suggested by the author. It is to be hoped that the legislatures of the various States will ultimately make some sort of progress in this direction. In New York State the only institution for this class is the Inebriates' Home, on Long Island; hence a large proportion of these cases are sent to lunatic asylums. Dr. Kerr undoubtedly stands at the head of writers upon this topic, at least in the English language; but he has many able foreign co-workers, such as Kovalevsky, professor of nervous and mental disease in the Russian university of Kharkoff, Monin of France, etc. F. P.

AMERICAN PUBLIC HEALTH ASSOCIATION, BROOKLYN, 1889.

The seventeenth annual meeting of this association will be held in the hall of the Brooklyn Institute, Washington and Concord Streets, October 22, 23, 24, 25.

The following topics have been selected for consideration at the meeting:

I. The Causes and Prevention of Infant Mortality.
II. Railway Sanitation.
  (*a*) Heating and ventilation of railway passenger coaches.
  (*b*) Water-supply, water-closets, etc.
  (*c*) Carrying passengers infected with communicable diseases.
III. Steamship Sanitation.
IV. Methods of Scientific Cooking.
V. Yellow-Fever.
  (*a*) The unprotected avenues through which yellow-fever is liable to be brought into the United States.
  (*b*) The sanitary requirements necessary to render a town or city proof against an epidemic of yellow-fever.
  (*c*) The course to be taken by local health authorities upon the outbreak of yellow-fever.
VI. The Prevention and Restriction of Tuberculosis in Man.
VII. Methods of Prevention of Diphtheria, with Results of Such Methods.
VIII. How far should Health Authorities be Permitted to Apply Known Preventive Measures for the Control of Diphtheria.
IX. Compulsory Vaccination.
X. Sanitation of Asylums, Prisons, Jails, and other Eleemosynary Institutions.

Exhibition of sanitary goods and appliances in another large hall close by.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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RECENT FRENCH CONTRIBUTIONS TO MEDICINE.

Horand, on Gonorrhœa among Women.—The author's researches were based upon the examination of 5,090 women, and 764 girls in hospital practice.

Any urethral discharge in girls is pathological. In virgins from 16 to 20 years of age occasionally one can obtain by pressing the meatus a milky or caseous drop, the product of a folliculitis, which contains no gonococci, and is not contagious. Among women who have sexual intercourse there is often a urethral discharge, which may be from a folliculitis, a simple urethritis, or gonorrhœal pus. Among 940 women Horand found folliculitis 146 times and 288 times a urethral discharge. Of the folliculitis cases only two revealed gonococci. The folliculitis never became gonorrhœal except when gonococci were found, when they all became gonorrhœal.

Urethral discharges in women are not all gonorrhœal, and urethral gonorrhœa is uncommon among them.

Discharges of a non-contagious nature appear after venereal excesses, drinking, irritation of the urethral mucous membrane, and under the influence of constitutional affections.

Generally gonorrhœa in women is uncomplicated and passes unnoticed; lasting months, perhaps years.

Vulvitis is rare among women, more common among girls. It may be irritative or gonorrhœal, and exist alone or be associated with a vaginitis or urethritis of the same nature. It is not often communicated to the vestibule.

Vaginitis is more common than vulvitis, and like it may be irritative or microbic.

It may be the only gonorrhœal lesion, and is rarer among women than girls, where it is more rebellious. The gonococcus probably may remain latent in the vagina. Among non-gonorrhœal women neither the menstrual blood, leucorrhœal discharge, nor lochial discharge are contagious.

Uterine gonorrhœa is rare, and may be complicated by pelvic peritonitis. It probably always coincides with a vaginitis.

Gonorrhœal inflammation of the vulvo-vaginal glands is a secondary condition or propagation of the gonorrhœa.

Aural gonorrhœa is comparatively frequent among women, but never exists alone.

Horand has never encountered aural, nasal, or buccal gonorrhœa.

From the examination of 483 women it transpires that among them the urethra is most commonly attacked, while among girls the vagina is the seat of predilection.

Among women gonorrhœal rheumatism and ophthalmia are rare, while the latter, on the contrary, is common among babies, often due, no doubt, to the employment of the method of Crédé.

In the treatment of urethral gonorrhœa, injections of nitrate of silver are best, while in the gonorrhœal vaginitis of childhood the best treatment consists of frequent irrigations with a hot boric solution, 1 to 1000, and instillations of powdered iodoform.

In the adult the vagina should be pencilled every four or five days with a crayon

of nitrate of silver, the same treatment being employed when the cervix or anus is implicated.—*L'Union Méd.*, Aug. 15, 1889.

Voituriez (J.) on the Erythema of Gonorrhœal Origin.—At the close of an article on the above subject the author gives the differential diagnosis between an erythema of gonorrhœal origin, and one which is seen during the administration of balsam copaiva, with which the former is apt to be confounded :

Copaivic Eruption.	Blennorrhagic Eruption.
Follows the administration of the medicine.	Appears irrespective of medication.
Stops quickly on suppression of medication.	Lasts frequently a week.
Generally takes the form of an urticaria or polymorphous erythema.	Is of rubeoliform or scarlatiniform type, and terminates in desquamation.
Is very itchy.	Itches little.
Locates about the hands, feet, elbows, knees.	Is often generalized, preceded sometimes by angina.
Recurs often when medicine is resumed.	Is not influenced by medication.
Unaccompanied by fever.	A real infectious complication, often febrile.
Often a history of other idiosyncrasies.	No individual predisposition.

—*Jour. des Sci. Méd. de Lille*, Sept. 6, 1889.

Guelliot (O.) on Pseudo-Orchitis from Strain.—In an article on the above subject, after narrating three personal observations, the author draws the following conclusions :

1. Orchitis from strain exists, but is rare.

2. It appears due to a sharp and energetic contraction of the cremaster, and sometimes to its contracture.

3. Often the strain is only a contributing cause of the inflammation, in that it renders painful a previously diseased testicle. It is necessary to seek the real cause in a lesion of the deep genital organs, deep urethra, and seminal vesicle.

4. A strain can produce a rupture of normal or altered spermatic veins. If the hemorrhage is limited to the lower part of the cord it may implicate the epididymis and simulate an epididymitis.

5. Pseudo-orchitis from a strain is generally on the left side, not circumscribed, of slight severity, and the presence of dilated veins is only appreciable after the reabsorption of the extravasated blood.—*Union Méd. et Sci. du Nord-Est.*, July 15, 1889.

Trousseau (A.) on a Case of Interstitial Keratitis Due to Acquired Syphilis.—Most authorities deny that an interstitial keratitis can occur in acquired syphilis, although Galezowski, Parinaud, Couzan, Horner, and Chadek have reported cases. A case of this description was treated in Fournier's service last year.

A woman of 25 entered St. Louis Hospital June 2, 1889, with what Fournier diagnosed an acquired syphilitic interstitial keratitis.

She gave no history nor presented no traces of hereditary syphilis. She was well developed and was neither rheumatic, gouty, tuberculous, or cachetic. She had acquired syphilis four years before, followed in due time by secondary and tertiary symptoms. The keratitis had appeared six weeks before admission.

The treatment consisted in hot compresses of borated water, atropine, a drachm of iodide of potash a day and an inunction of a drachm of mercurial ointment.

As the cornea cleared up fine opacities of the vitreous came into view. The sight steadily improved and became perfect, all opacities of the cornea and vitreous disappearing.—*Anns. de Dermat. et de Syph.*, Feb. 25, 1889.

Nuel on Intra-ocular Injections.—The author has experimentally studied the effects of intra-ocular injections upon the epithelial elements which line the anterior chamber.

Injections of simple water wash off the epithelium of the membrane of Descemet in 15 to 30 seconds. Mercurial solutions accomplish the same result in 10 seconds. Four per cent. boric solutions alter the anatomical elements very little, while a solution of chloride of sodium does not alter them at all.

It has been demonstrated that microbes are not killed by intra-ocular injections of antiseptic liquids, and on the other hand they have been proved often harmful. If, then, intra-ocular injections for mechanical purposes, such as removal of the crystallin lens, are needed, a boiled solution of common salt is sufficient and harmless.—*La France Méd.*, Aug. 13, 1889.

Galezowski on a New Treatment of Retinal Detachment.—The eye being fixed and anæsthized by cocaine, the author introduces into the sclerotic at the edge of the ciliary circle a curved needle carrying a fine catgut thread. He pushes the needle backwards as far as possible, across the detached membrane, so that it

reaches the limit of detachment. He draws the needle through at this point and bringing it back ties the catgut on the surface of the sclerotic.

He then applies a compress to the eye for 10–15 days, changing the dressing each day. An essential for success is that the loop of thread embrace the greatest fold of the detached retina.—*Gaz. Hebd. des Sci. Méd. de Bordeaux*, July 20, 1889.

Costomiris on Direct Massage of the Conjunctiva and Cornea.—Having everted the eyelids, the author spreads upon the conjunctiva a thick layer of impalpable powder of boric acid, and then, with the fingers of the right hand, rubs the conjunctiva, the *culs-de-sac*, the angles of the eye, and finally the cornea, if it is involved in the disease. The eye is then irrigated with a solution of boric acid, and this lavage is followed, for a few days, by the instillation of a solution of nitrate of silver, 1 to 200 or 300, to prevent the inflammation which sometimes follows.

Short and light friction should be at first employed, and this should be increased or diminished according to circumstances. This manipulation should be repeated daily, and continued during two to four weeks after recovery.—*Le Courrier Méd.*, Sept. 14, 1889.

Blanch (A.) on the Treatment of Diphtheritic Conjunctivitis.–The treatment consists of irrigation with a boric-acid solution or with a 2 : 1000 sublimate solution, the detachment of false membranes with a probe or forceps, rubbing the mucous membrane with lint dipped in lemon juice or tartaric acid, and lastly the application of some substance to prevent the re-formation of the false membrane. This substance is hélénine, which seems to act specially upon the microbe of diphtheria, and which also increases conjunctival vascularity and secretion.—*La France Méd.*, Sept. 3, 1889.

Sponck on the Action of the Diphtheritic Poison upon the Kidneys.—An examination of the false membrane taken from living victims of an epidemic of diphtheria revealed the presence of the bacillus of Klebs in all instances.

With a pure culture of this bacillus it was possible to reproduce the disease by superficial inoculation. Even the paralytic symptoms were not wanting in many instances. Subcutaneous inoculation and intra venous injection often killed the animals, but in all instances in rabbits produced albuminuria and a real nephritis—as proven by autopsy.—*L'Union Méd.*, Aug. 31, 1889.

Paul (C.) on the Antiseptics Adapted to each Pathogenic Microbe.—The author first gives the minima of some antiseptics capable of preventing putrefaction of a litre of neutralized beef-tea.

1st. Substances eminently antiseptic :

	gram.
Oxygenated water	0.05
Corrosive sublimate	0.07
Nitrate of silver	0.08

2d. Substances very powerfully antiseptic :

Iodine	0.25
Chloride of gold	0.25
Bichloride of platinum	0.30
Hydrocyanic acid	0.40
Bromine	0.60
Sulphate of copper	0.90

3d. Substances strongly antiseptic :

Cyanide of potassium	1.20
Bichromate of potassium	1.20
Ammonia (gas)	1.40
Chloride of aluminium	1.40
Chloroform	1.50
Chloride of zinc	1.90
Thymic acid	2.00
Chloride of lead	2.00
Nitrate of cobalt	2.10
Sulphate of nickel	2.50
Nitrate of uranium	2.80
Carbolic acid	3.20
Permanganate of potassium	3.50
Nitrate of lead	3.60
Alum	4.50
Tannin	4.80

4th. Substances moderately antiseptic :

Hydrobromate of quinine	5.50
Arsenious acid	6.00
Sulphate of strychnine	7.00
Boric acid	7.50
Arsenite of soda	9.00
Hydrate of chloral	9.30
Salicylate of soda	10.00
Sulphate of iron	11.00
Caustic soda	18.00

5th. Substances weakly antiseptic :

Protochloride of manganese	25.00
Chloride of calcium	40.00
Borate of soda	70.00
Hydrochlorate of morphia	75.00
Chloride of barium	95.00
Alcohol	95.00

6th. Substances very weakly antiseptic :

Chloride of ammonium	115.50
Arsenite of potash	125.00
Iodide of potassium	150.00
Sea salt	165.00
Glycerine	225.00
Sulphate of ammonium	250.00
Hyposulphite of soda	275.00

The typhoid bacillus is kept from developing by the following substances in the following proportions:

Corrosive sublimate	1 to 20,000
Sulphate of quinine	1 " 800
Carbolic acid	1 " 200
Hydrochloric acid	1 " 100
Chlorinated lime	5 " 100

The cholera bacillus will not develop in an acid menstruum. A drop of a 1 % solution of hydrochloric acid prevents its culture. Other agents oppose its development as follows:

Corrosive sublimate	1 to 100,000
Sulphate of quinine	1 " 5,000
Sulphate of copper	1 " 500
Carbolic acid	1 " 400

The following are substances which completely sterilize cultures of tubercular bacilli:

Hydrofluosilicic acid.	Fluosilicate of potassium.
Ammonia.	Polysulphide "
Fluosilicate of iron.	Silicate of soda.

Small amounts of the following substances have an appreciable inhibitory effect on cultures of tubercle bacilli:

Acetate of soda.	Picric acid.
Arsenious acid.	Pyrogallic acid.
Boric acid.	Sulphurous acid.
Methylic alcohol.	Ethylic alcohol.
Nitrate of potash.	Iodoform.
Benzine.	Menthol.
Creasote.	Nitro-benzine.
Chloroform.	Salol.
Ether.	Sulphate of aluminium.
Hyposulphate of soda.	Toluene.

In solutions of the following substances cultures develop but with great difficulty:

Acetanilide.	Arsenite of soda.
Acetone.	Nitrate of potash.
Aldehyde.	Bichromate of ammonium.
Ammoniacal alum.	Binioide of mercury.
Chromic alum.	Spirits of turpentine.
Caffeine.	Eucalyptus.
Chlorate of potash.	Iodide of potassium.
Chloride of aluminium.	Resorcin.
Lactate of zinc.	Sulphite of soda.
Sulphate of soda.	Terpin.
Sulphate of zinc.	

The following substances do not hinder the culture of tubercle bacili:

Benzoic acid.	Biborate of soda.
Salicylic acid.	Bromide of camphor.
Uric acid.	Chloral.
Benzoate of soda.	Urethane.

Tuberculous matter heated for 20 minutes to 60° (Cent.), 10 minutes to 71° (Cent.) or completely dried at 30° infects guinea-pigs as quickly as fresh material. Morsels of tubercular tissues left to macerate or putrefy in water of ordinary temperature for 5 to 20 days, or frozen and thawed successively, still retain their infectious properties.

Typhoid bacilli develop at a temperature of 40° (Cent.), better where the temperature is 25° to 35° C. At 46° growth ceases. They retain their vitality a long time. Cultures are still fertile after six months. The spores endure a prolonged desiccation and they easily resist freezing.

Cholera germs have a feeble vitality. Cultures perish after drying a half hour at ordinary temperature. In liquids 50° to 55° suffices to kill them. Very weak solutions of mineral acids and stronger solutions of organic acids kill them. Cholera bacilli do not flourish in sterilized water. Water rich in organic matter is most favorable to their development. The temperature of of 30° to 40° C. suits them. Below 16° (C.) development ceases. They endure a freezing temperature one hour. The pneumococcus of Fraenkel does not develop below 24° (C.) nor above 42° (C.). It likes best 35° (C.). Its vitality is very feeble.—*La Tribune Méd.*, Sept. 12, 1889.

Verneuil on the Pathogeny of Microbes Found in Malignant Tumors.—The author's conclusions are as follows:

1. The tissue of malignant neoplasms, cancers, sarcomas, epitheliomas, etc., may be invaded at any given moment by different microbes, of which it is impossible to determine surely the origin, kind, or number.

2. This invasion, of which the cause and mechanism are equally unknown, may remain a long time latent, or may, in certain cases, result in the evolution and nutrition of tumors, some of which rapidly increase, soften, and ulcerate.

3. Microbes are not found in all sorts of neoplasms, nor in all neoplasms of the same sort, nor in all parts of the invaded growth. They cannot be found in lipomas, pure fibromas, nor in forming sarcomas or cancers of a chronic nature in the crude state with unbroken skin; but they are found almost constantly in broken down, ulcerated neoplasms.

4. These microbes, beside their irritant pyrogenic action which they exert upon the tissue of the tumor invaded, possess other pathogenic qualities which involve the whole economy. Thus they are capable of lighting up a more or less intense and irregular fever while they are still shut

up in a tumor in the course of rapid growth or softening.

Moreover, during the removal of a tumor containing them, they are able, mixed with the fluids of the softened points, to infect the operation wound in such a way as to develop a septicæmia capable of producing death.

5. The knowledge of this latter fact, besides being an argument in favor of early removal of malignant neoplasms, so desirable from all points of view, points out to surgeons certain preventive measures to be taken during and after the extirpation of tumors infected by microbes.—*La France Méd*, Sept. 7, 1889.

Phthisis of Traumatic Origin.—Jaccoud, in the *Jour. de Méd. et de Chir.* for Aug., 1889, gives the histories of three patients where phthisis followed and seemed to be caused by a traumatism. A man of 56, in good health was crushed between two wagons, the chief injury being borne by his chest. He was unconscious for fifteen minutes, and spit up some blood. There were no fractures or external lesions. In eighteen months indubitable phthisis had developed.

In the second case a man was entombed in a sewer, and, besides his injuries, breathed noxious gases for some time. He had a traumatic pneumonia, which slowly developed into phthisis, as shown by autopsy a year after the accident.

In the third case, a man of 48 had a hemoptysis, produced by a violent muscular effort. A pneumonia followed this, and phthisis developed and proved fatal in three months. According to the author's experience, phthisis of traumatic origin invariably runs a very speedy course.

Besnier (E.) on Pityriasis Rubra Pilaris.—In the treatment of this disease the author advises as follows:

At first, of course, the diet and hygiene appropriate to each case; arsenic with caution; cod-liver oil in some cases; baths as frequent and prolonged as possible; inunctions of oils, glycerines, fats, containing salicylic acid or menthol, to relieve itching; if the disease is general or extensive, frictions with soaps or pomades containing naphthol, salicylic or pyrogallic acid, with preparations of oil of cade, cod-liver oil; if the disease is localized, prolonged applications of different plasters, with oil of cade, pyrogallic acid, cod-liver oil, mercurial plasters, or gelatin medication, renewed after each bath.—*Annales de Dermat. et de Syph.*, June 25, 1889.

MISCELLANY.

Fatal Puerperal Fever Caused by Discharge from the Lachrymal Sac of the Attendant.—Dr. M. Loeb, of Frankfort-on-the-Main, gives interesting details of a series of cases of puerperal fever occurring in the practice of a midwife, in some instances running a fatal course, the only discoverable cause for which was a blennorrhœic discharge from the lachrymal sac of the midwife in attendance.

The first case reported was that of a healthy woman, æt. twenty-nine, who gave birth to a healthy child after an easy labor. Twenty-seven hours afterwards she was taken with abdominal pain, difficulty of breathing, and rattling on the chest. The chest symptoms afterwards subsided, and the abdominal ones got worse. The abdomen became distended, and the patient died on the sixth day after delivery. The autopsy showed the uterus still large, a slimy purulent layer on the mucous membrane; a flat wound on the cervix uteri; slight phlegmonous inflammation of the left parametrium, with lymphangitis; general peritonitis, and slight pleurisy.

Then came the search into the cause of the illness, which was plainly of an infectious nature. It was shown that the midwife had disinfected her hands in a three-per-cent. carbolic solution; that the last twelve cases attended by her had all recovered. Still, the gentleman called in felt sure from various causes that the infection had been communicated by the midwife in attendance, but he was quite in the dark as to the particular mode in which the communication was made. The first clue came from the health officer of the district, who assured Dr. Loeb that that was the fourth fatal case in the practice of the midwife in the short space of three months. A gentleman practising in the district supplied other data. One parturient woman died three months before with rapid septic peritonitis with copious exudation, and with purulent contents in the tubes. Two other cases occurred later, but they were not thought sufficient to justify a complaint. There were thus four fatal cases of puer-

peral peritonitis in the practice of one midwife between the end of April and the middle of July last year. The singular similarity of the symptoms pointed to an identical poison in all the cases. The poison could not be carried from one patient to another, as the great interval of time between the fatal cases and the large number of intercurrent cases—twelve—which escaped the poison proved. It was probably something peculiar to the midwife herself. On searching very carefully, he discovered a cicatrix on the cheek resulting from a lupus that had healed. The thought immediately occurred, may there not be stenosis of the lachrymal canal here, or blennorrhœa of the sac? There was, in fact, stenosis of the lachrymal canal. On pressing in the neighborhood of the sac, pus came out of the lower lachrymal canal. The fact that the pus from this part contains the staphylococcus pyogenes in ninety per cent. of cases, as well as numerous other pyogenous micro-organisms, rendered it probable that in spite of frequent disinfection of the hands the finger of the midwife had conveyed the poison direct from the eye to the patient. What is known further of the cases increases the probability that this was really the channel of infection. From July, 1888, to July, 1889, is a year, and the fact that although the midwife has continued her practice as before, but without another fatal case occurring, and that she has throughout acted on the supposition that the lachrymal sac was the origin of the fatal diseases, renders it extremely probable that the danger did indeed lurk in that little-suspected drop on the cheek. The case recalls the tragic one related by Meigs, of the American physician, whose midwifery practice was frightfully deadly, and who was subsequently discovered to be suffering from an ozæna that was the cause of all the havoc he wrought. The route was very direct, from the ozæna to the handkerchief, from the handkerchief to the hands, and from the hands to the vaginal discharge, or lacerations of the patients.—Berlin correspondence of the *Med. Press*, Aug. 28, 1889.

The Etiology of Goitre.—Dr. Th. Kocher, of Berne, first of all determined accurately in what parts of his own canton goitre was common. On comparing the water of these regions with that of goitre-free neighborhoods, he finds that the one striking difference is that where goitre is abundant the water contains a considerable quantity of organic or organized material, and he concludes that it is this factor which determines the prevalence of goitre in any district. He finds that in certain goitrous parts particular families who have access to special water-supplies in which there is not this quantity of organic matter remain free from goitre, although breathing the same air, living on the same soil, engaging in the same occupations, and eating the same food as their very goitrous neighbors. On comparing the chemical composition of goitrous and non-goitrous water in the Berne canton, the only other difference he found was that the quantity of sulphate of lime was less in the goitrous; but, as it is well known that goitre is often found in those who drink water richly laden with this salt, this difference cannot explain the great pathological fact. Dr. Tovel has found that the water in goitre-free parts contains a very minute quantity of micro-organisms. And it has further been shown that if goitrous water is injected into rabbits the thyroid gland is very prone to swell, although in dogs the injections have no effect. Kocher's investigations do not certainly completely clear up this difficult subject, but they throw some light upon it, and as such are to be heartily welcomed.—*Lancet*, Sept. 14, 1889.

Hamaker (W. D.) on a Case of Ovarian Tumor in a Girl Seven Years Old; Ovariotomy; Recovery.—The writer was called to see a girl of seven October 22, 1888, and learned that her family history was good, no hereditary disease having existed, nor had there ever been a case of ovarian tumor in the family. There was no history of injury, nor had she shown any of the signs of puberty. She had been in good health until April, 1888, when she began to fail gradually in health, with pain in the left side and a slight tendency to bend forward in walking. During the spring and summer she continued to fail in health, and had considerable dyspnœa. In August the parents first noticed abdominal enlargement, and also noticed the "blue veins" over the abdomen. During this time she had been treated for various diseases. When first seen she was anæmic and very much emaciated. She was unable to lie down, on account of the dyspnœa and pain just below the region of the liver. She was passing large quantities of limpid urine,

which was low in specific gravity and without albumen.

She was aspirated on November 4th, and six pints of dark ovarian-like liquid drawn off which, under the microscope, revealed the usual cells of ovarian fluid. After the aspiration a tumor the size of a child's head could be made out, apparently growing from the *left* ovarian region. She was now quite comfortable, and in a few days was able to be about the house.

Jan. 3, 1889, after a course of tonic treatment, ovariotomy was performed with strict antiseptic precautions. A short incision was made from the umbilicus to a point an inch above the pubes. A few adhesions were found at the point of aspiration, and also the omentum was found adherent at several points. These were easily broken up and the contents of the cyst drawn off. The sac was now drawn from the opening, and, instead of arising from the *left* ovary, as it appeared after the former aspiration, it was found to be a cyst of the *right* ovary. There were one large cyst and several "daughter" cysts, and the tumor was attached by means of a long pedicle. The cyst had the glistening appearance of the ordinary ovarian tumor. The pedicle was ligated with strong silk, cut off, and dropped. No bleeding point required a ligature, and the cavity was quickly cleansed and the abdominal wound closed with silk sutures. A strip of lint well covered with carbolized vaseline was laid over the wound, and over this was laid salicylated cotton. Over this was placed a large pad of absorbent cotton and the bandage applied.

Perfect and prompt recovery followed.

Cases of ovarian tumor before puberty are very rare. The youngest patient operated upon was that of Roemer, of Berlin, who removed successfully a congenital tumor from a child twenty months old, which proved to be a dermoid cyst as large as a child's head.[1] Roemer collected a number of additional cases. Dr. Neville, of Dublin, operated on a child aged two years and eleven months; Busch had a case at two years of age, and Alcott's patient was three years old. All of these cases were unsuccessful. Schwartz successfully removed a large proliferating tumor from a child four years old with precocious puberty. Barker had two cases, and Knowsley Thornton one case at seven years, while Spencer Wells, Cupples, and Chenoweth had each a case at eight years.[2] In addition to these cases collected by Roemer, Wegscheider reports a bilateral cystoma, in a girl twelve years old, which weighed about seven pounds, and Marjolin removed a multilocular tumor, weighing nineteen pounds, from a girl eleven years old. Gaillard Thomas removed, *post mortem*, a large tumor from a child aged three and a half years.[3] A second case, three years old, is reported, but the operator's name is not given.

Among one hundred and ninety-seven cases of dermoid cyst collected by Pauly, Lebert, and Olshausen, seven cases were in children under ten years of age.[4] A number of cases of sarcoma and carcinoma of the ovary, in those under twelve years, are reported by Olshausen and others. Lucas reported to the Clinical Society of London, in 1888, a case of round-celled sarcoma, which he had removed successfully in February, 1885, from a girl, seven years old, who had exhibited precocious puberty.[5]—*N. Y. Med. Jour.*, Sept. 14, 1889.

The Behavior of the Germs of Cholera, Typhoid, and Tuberculosis in Milk, Butter, Whey, and Cheese.—Amongst the numerous labors of the Reichsgesundheitsamt has been that of determining the behavior of certain germs of disease in various articles of food. Milk is one of the most common articles of diet, and one of the health-office collaborateurs, L. Heim, of Würzburg, has lately concluded a lengthened inquiry into the relations of the bacilli of tuberculosis, cholera, and typhoid fever to it, and its products, whey, butter, and cheese. That milk is a favorite medium for dissemination of disease is well-known, and Koch, amongst others, has shown that it is peculiarly adapted for this purpose. As regards cholera, the germs of the disease were still viable after remaining for six days in milk that had undergone no antisepticizing processes; in milk of the same character that had been kept in the ice-chest, on the other hand, no living bacteria were found at the end of three days. This part of the inquiry shows that cholera bacteria remain active in fresh milk the whole length of time it is custom-

[1] *Brit. Med. Jour.*, April 12, 1884. [2] *Ibid.*
[3] Olshausen: "Cyclo. of Obstet. and Gyn.," vol. viii., p. 80.
[4] *Ibid.*, p. 354.
[5] *International Jour. of Surgery*, July, 1888.

ary to keep it, and that they do not lose their dangerous quality for some days after the milk has become sour. The same germs were found active under some circumstances even at the end of the month. In ordinary strong cheese they did not retain their viability over a day, neither did they in unripe cheese.

The bacilli of typhoid were alive and capable of development in milk at the end of thirty-five days, but no longer so at the end of forty-eight days; in butter they remained active between three and four weeks; in cheese only three days, and in whey only during the first day. Tubercle bacilli remained capable of development for ten days in fresh milk; in milk gradually undergoing decomposition they lost their power in a period varying between ten days and four weeks; in butter, on the other hand, they retained their full power at the end of four weeks; in whey and cheese after two weeks, but not after four weeks. The practical importance of the investigations is so obvious as scarcely to need pointing out, and its bearing on the use of milk, and that of preservation, carriage, preparation, and sale of its products is equally obvious. Something has been done, much remains to be done, to stop the ravages of disease, and the labors of Dr. Heim are another step forward.—*Med. Press*, Sept 11, 1889.

Sharples (C. W.) on Ulnar Neuritis, Caused by a Hypodermic Injection of Ether.—A woman of forty was admitted June 11, 1889, for very remarkable hysterical phenomena, assuming a fixed "spastic" condition of all her voluntary muscles, and especially of the back; being at one time in a full opisthotonic position she attempted to throw herself out of bed, etc. One attack was allowed to go by unnoticed but in three days' time there occurred a second one of a similar nature. She appeared unconscious to all external influences when in this condition.

It occurred to me that a hypodermic of either might be as painful as any thing and of easier application than cold water immersions, and the like, and would in the same way break up the spasm and produce immediate relaxation.

The left arm was taken and twisted from under the body so that the ulnar surface was the accessible part, into which the hypodermic needle was thrust, care taken to avoid the vessels, but no thought being given to the nerves. The injection consisted of twenty minims of ether, all being thrown into one place, and evidently caused great pain accompanied by immediate relaxation of her "spastic" state.

In eighteen hours or less after the administration the entire forearm was swollen nearly twice its thickness and somewhat reddened. With this there came the tingling sensation, and the sensation as though pins and needles were being stuck into her fingers (the little one and the adjoining one), which has persisted ever since, off and on, present most of the time. Pain extended from just above the elbow to the ends of the same fingers. Tenderness on pressure was present over the same region as the pain and very noticeable over the internal condyle where the ulnar nerve is most accessible to pressure. When examined three weeks after the origin of the neuritis, tenderness was found along the inner side of the arm and in the brachial plexus. Along the other branches of the plexus no tenderness could be elicited. Pain, too, at this time had the same distribution as tenderness on pressure. There is a curious sensation as though these two fingers were being constantly drawn by some power tending to flex them; and they remain in a semi-flexed position. There is a sense of weight over the ulnar part of the hand and the corresponding fingers.

When she entered the house, the nails were brown. Since that time the new growth has been of a natural hue, and by means of this we can measure the difference between the amount of growth on the affected fingers and the unaffected ones, which is marked. Proportionately there is more of the brown and less of the nail of natural appearances on the little finger and adjoining one than on the others. These two fingers are commencing to be glossy.

The branches of the ulnar nerve supplying the skin, come off from the lower two-thirds of the nerve, or about the middle of the forearm. One anterior branch comes to the surface near the wrist, and the other cutaneous one comes to the surface on the ulnar integuments of the palm of the hand. The posterior part is supplied by the dorsal cutaneous, arising two inches above the wrist, and running along the ulnar side of the hand. As nearly as possible, sensation as tested with a pin-point is found to be practically gone over these areas. Along

the inner surface of the arm sensation is very good. One other point worthy of note is the fact, that pain was not so intense at the point of administration as in the parts to which the nerve was distributed. There was no stage of hyperæsthesia.

Treatment consisted in a splint and lead water and laudanum in the early stages, with marked comfort to the patient, and the subsequent application of blisters along the painful nerve over the brachial plexus. She is doing very well with a gradual diminution of symptoms.—*University Med. Mag.*, Sept., 1889.

Thornton (B.) on Amputation of Foot, with Rapid Union, in Spite of Syphilis, Gout, and Delirium Tremens; Remarks.—This case presents an example of recovery from amputation of the leg when many constitutional conditions unfavorable to rapid healing were present. Mr. Thornton attributes the success chiefly to the antiseptic treatment employed.

The patient, a debilitated man, aged thirty-eight, was admitted early in February, suffering from disease of the right tarsus, which eventually turned out to be of a tertiary specific origin. Mr. Treves, who first had charge of the case, made incisions into the foot and got away some necrosed bone on February 22d. In spite of the operation, the foot remained swollen and inflamed, and the evening temperature varied between 100° to 101°. As the man was rapidly going to the bad, and the foot began steadily to get worse, it was decided to amputate in spite of the man's unfavorable condition, for already he had characteristic gouty inflammation of several joints. On March 3d, in Mr. Treves' absence, Mr. Thornton amputated the foot three inches above the joint by Teale's method, using the ordinary antiseptic precautions; two small drainage-tubes were inserted at the angles of the wound, and iodoform oil and liberal absorbent-wool dressings applied. The amputated foot was totally disorganized, and had the horribly offensive odor so often met with in syphilitic bone disease. The amputation wound healed steadily and well, and by the eighth day was firmly healed, with the exception of two small superficial places at the angles of the wound.

The interesting features are: firstly, the extreme debility of the patient; secondly, the syphilitic condition leading to the operation, which condition was proved by the history of the patient and the evidence of scars about the legs; thirdly, the gouty inflammation of various joints before the operation and for a fortnight afterwards; and, fourthly, the onset of alcoholic delirium, with visions of a big black dog, etc., two days after the operation, lasting more or less for a week or ten days. To add to the patient's danger, there had just been a very bad case of erysipelas in the adjoining ward, from which he was mercifully spared. It is rare that an amputation should heal so readily under such extreme and varied pathological difficulties. In this case there were two more interesting features which are worthy of note, the first being the formation of an abscess extending from the head of the fibula to within two inches of the operation wound, with which it had no connection whatever. It appeared to me that it might be due to the pressure of the Esmarch's india-rubber tourniquet, which was used with the ordinary amount of tightness at the operation over the old specific scars. Eighteen days after the amputation the patient was anæsthetized, and I opened the abscess above and below, and, as a second interesting feature, I pulled out a firm pyogenic membrane, which had the appearance and consistency of the fœtal membranes. A drainage-tube was passed through the cavity of the abscess, and membrane was discharged for about a week afterwards; and in another ten days the abscess cavity was obliterated and the two wounds quite healed. The case presented so many features of interest that I thought it worth recording. The surgeon has frequently to risk operation in syphilitic and alcoholic cases, but he is rarely called upon to operate in acute gout, and more rarely still in the presence of all three, to say nothing of the dread shadow of erysipelas in the background. The fact that this man successfully ran the gauntlet of all these foes speaks well for the blessings of antiseptic surgery, or at any rate for the vitality of the human race at the close of the nineteenth century.—*Lancet*, Sept. 14, 1889.

Ewens (J.) on Operations upon Aged Persons.—In the report by Mr. G. C. Peachey, in the *Journal* of July 20th, he alludes to the age of his patient (seventy-two years) as a reason for not performing an operation for removal of an epitheliomatous ulcer behind the lobe of the ear. I

have had to perform several operations on aged persons, and have been struck with their capacity for bearing them. I forward brief reports of four cases which occur to me just now.

Case I.—A man, aged seventy-five, had suffered for five years from epithelioma of the lower lip, which had extended so far that nothing but complete removal of all the soft tissues, nearly to the chin, would suffice for complete removal of the diseased structures. Perfect recovery took place, and the patient lived for nine years after without recurrence of the disease.

Case II.—A man, aged sixty-six; case similar to the last; perfect recovery ensued, and the patient was alive and well five years after. In both these cases the severity of the operation was enhanced by the performance of a plastic operation for making a new lip, bringing up the flaps from below the chin, and united in the mesial line. These cases were fully reported as follows: Case I. in the *Lancet*, August 1, 1868; Case II. in the *Lancet*, February 22, 1873.

Case III.[1]—A woman, aged eighty-seven, had suffered for some months from epithelial cancer, supervening upon a wart upon the forefinger. After repeated attacks of bleeding, endangering her life, she consented to amputation of the finger; but the disease had so nearly reached the metacarpo-phalangeal articulation that amputation had to be performed through the metacarpal bone. The patient recovered completely in ten days, and lived six years after; no recurrence of disease.

Case IV.[1]—A man, aged seventy-eight, with extensive epithelioma of cheek involving almost the whole of the face. Complete removal of diseased tissues, with perfect recovery and no return of disease. The patient lived to the age of eighty-two.—*Br. Med. Jour.*, Sept. 14, 1889.

Somers (A. B.) on a Singular Case of Concussion from Explosion of Giant Powder.—While engaged in breaking up frozen earth with giant powder, a man put a half-pound stick of the powder that had got wet and was frozen near a fire built on the ground to thaw.

While standing about two feet distant, with his left side nearest the fire, the powder exploded. I saw him about one hour later. There were no powder marks upon his person, but his left leg was covered with ecchymoses from the top of his shoe to his knee, on the outer and anterior portions, some spots being almost black, and in several places the injury was so severe that the skin sloughed.

A portion of his left wrist, between his sleeve and mitten, being bare, was completely covered with drops of blood, exuding through the skin from broken capillaries. There was rupture of the left membrana tympani, with hemorrhage from the internal ear and total deafness on that side. Left eye uninjured. Pupil of right eye contracted; could distinguish light with this eye, but could not count fingers. The entire face, neck (in front and to the left), and right eye covered with ecchymosed spots and drops of blood from ruptured capillaries. There was also nose-bleed and expectoration of blood from the throat and air passages. Considerable mental confusion.

The next day expectoration of blood had stopped. Vision of right eye much improved. From this time all the symptoms improved rapidly, except the deafness of left ear, which lasted for several weeks, but finally got well, or nearly so.—*Omaha Clinic*, August, 1889.

Talbot (R. M.) on a Series of Cases of Puerperal Fever.—On July 24th of this year a midwife attended an ordinary confinement; the woman died a few days after. On July 30th she was called to another, and found the woman lying on the floor confined. She removed the afterbirth, and the woman died on August 2d. An inquest was held, preceded by a post-mortem, and the death certified as "puerperal fever." On the 7th she was called to another, examined her, and after a while, saying that the case was a difficult one, sent for a medical man, who delivered the patient, and she died a few days after of puerperal fever. On the 14th another case was attended by her, which also ended fatally a few days after. On September 8th another confinement occurred in the top room of her own house. She was with the patient—her own daughter—for an hour before sending for another woman (her sister) to act. The midwife did not actually accouche her daughter, but her daughter died of puerperal fever on the 13th.

[1] *Lancet*, vol. ii., p. 85, 1877.

The connection between these cases is so obvious that I think it calls for no remark from me, but the following fact may throw some light upon the cause of the first case. The midwife was suffering from specific disease in the tertiary stage, and about the 28th of July had a large piece of loose necrosed bone—the stench from which was abominable—removed from the roof of her mouth. This bone had been exposed for at least a month. Had she been fidgetting this piece of bone about with her finger, and conveyed septic material to her patient?—*Lancet*, Sept. 21, 1889.

Bland (D. W.) on a Case of Multiple Gestation.—I do not know at what age the woman was married, but during her marital relations she was the mother of the rather remarkable number of *twenty-eight* children at full term. The record of births I do not recall, but I do know that out of this number there were but two single births—the balance were in twins upon several occasions, triplets twice or three times, and quadruples once. The quadruple birth the children lived to grow up, and one of the number, a female, died from traumatic peritonitis some few years ago. The mother was a large, stout woman, and reached the age of over sixty years. Her habits of life were those peculiar to hard out-door work and plenty of it.—*Jour. Am. Med. Assoc.*, Sept. 28, 1889.

Baker (A. W. W.) on Polypus of the Gum.—These tumors vary from the size of a pea to a horse-chestnut, and are found on the gum in the neighborhood of diseased teeth. They are said to be chiefly caused by the ragged edge of a carious tooth, but it is probable that the ptomaines resulting from the operations of the bacteria in the dentinal tubules have more to do with their etiology than is usually supposed. Wedl and Rothman, in their writings, support this view. The growths in question are essentially papillomatous, and exhibit on section large branching papillæ covered with a thicker layer than normal or squamous epithelium. The polypi are purely local in their origin, and non-malignant.—*Lancet*, Sept. 21, 1889.

Bateman on the Jurisprudence of Aphasia.—The author mentioned many cases to show that a patient might be permitted to make a will, which was admitted to probate, although unable to explain himself in speech. Probate was granted in 1870 to the will of a man who had been a deaf-mute. There was also a very remarkable case where a widower, aged sixty-three, about to marry a young lady, was suddenly seized with aphasia. This gentleman showed by signs that he desired to leave £30,000 to the lady he had intended to marry. After death, it was shown by evidence that, on being asked what he wished to leave, he put up the five fingers of his hand, and on being asked if that meant £5,000, he nodded. He held up his hand six times, and was asked whether that meant £30,000. He was then asked if he desired to leave this sum to Miss R——, and he nodded his head. Asked whether this was to be left unreservedly to her, he shook his head. Asked whether the money was to be for her use during her lifetime, he nodded his head. The will was made up and witnessed according to these instructions, and patient affixed his mark. When the case came before the court, the judge said he would have granted probate if the mark of the testator had been put in the right place, but it was made on the body of the deed and not at the end, and this made the document useless. A similar case had occurred in an aphasic gentleman, aged sixty-two, in France, who could not write without copying his handwriting, and whose will was disputed by the courts. In this case the patient's intellect was excellent, and he could keep up a conversation by means of the deaf-and-dumb alphabet. These were all cases of motor aphasia. When there was sentient aphasia, doubtless the case was more difficult, as the intelligence was thus lessened.—*Med. Rec.*, Sept. 28, 1889.

Unusual Mode of Suicide.—On the 28th of August an inquest was held at Lincoln on the body of a woman, aged thirty-eight, who had been found dead in her room early that morning. The medical man who was first called in found the woman lying on the floor, apparently dead; blood had flowed from the nose and mouth, and there was much blood about the room, especially on the carpet. Examination of the mouth revealed the presence of the sharp broken end of a hand mirror, which was just within reach of the forefinger, was about four inches in length, and was removed with some difficulty. A hand looking-glass had been found on the dressing-table; this was spotted with blood, and the handle had been broken off close to the

mirror. At the post-mortem examination a sharp piece of wood, about two inches in length, was found lying between the posterior wall of the œsophagus and the cervical spine; this fitted the mirror and the broken handle previously removed. There was an opening in the lower part of the pharynx near the commencement of the œsophagus, through which the wood had penetrated, and some of the muscles in front of the spine were lacerated. Death was ascribed to suffocation by pressure of the foreign body on the larynx. It was supposed that suicide had been committed by the deceased whilst under the early effects of opium poisoning, that she had forced the mirror handle foremost into the mouth, and that it had broken at the junction of the handle and mirror. From the description of the broken handle, and the way in which it was splintered and impacted in the pharynx, the idea is suggested that the woman might have held it in her mouth and fallen forward on the floor, thus driving it forcibly against the spine, and causing the point of the handle to run downwards in front of the cervical vertebræ. It is difficult to imagine any one of sufficient strength and determination to produce the result described without some such assistance. The finding of the mirror on the dressing-table lends support to the view given in the medical evidence, but does not disprove the other supposition—either implies great determination on the part of the woman. Almost all the injuries causing perforation of the pharynx, excluding gunshot wounds, have been produced by a person falling forward on the ground, and so forcing a pipe or similar thing into the mouth, or a blow has been struck by some one and a similar result produced, the blow having struck the foreign body and forced it backwards.—*Lancet*, Sept. 21, 1889.

Buchman (A. P.) on Colon Flushing in Typhoid Fever.—The author thinks that from one to three quarts of cold water can be easily and safely passed into the colon, which will rapidly lower a high temperature. Some of this water passes the ileo-colic valve and enters the small gut. Tympanitic distension always disappears with the passing away of the water so injected. Putrefactive fermentation of the bowel contents is prevented by such use of water, as toxic substances are more rapidly absorbed by the cæcum than by any other portion of the intestinal canal.—*Med. Record*, Sept. 28, 1889.

Bell (T. W.) on a Large Renal Calculus.—The patient died in the Auckland Hospital on March 31, 1889. He had previously had marked symptoms of renal calculus. The patient would not submit to an operation.

The post-mortem showed the kidney greatly enlarged. It measured 9¼ inches in greatest length, and 21¾ in greatest circumference. With capsule and adhering fat it weighed 4½ lbs. The kidney tissue was thinned and atrophied. On opening the kidney a quantity of purulent matter escaped. In the interior of the kidney was a large calculus and three small ones. The large stone was broken during removal and weighed 1 lb. 5 oz. The smaller stones weighed together 2¾ ounces—giving a total of about 1½ lbs. The stone was white and glistening outside, and had evidently formed on a darker nucleus—"fusible calculus." It was shaped like a greatly enlarged cast of the pelvis of a kidney. The smaller calculi were like flat water-worn shore pebbles.—*Australasian Med. Gaz.*, Aug., 1889.

Schuelt on the Presence of Microbes in the Bullæ of Polymorphous Erythema and Varicella.—In the former disease the author has found, isolated and cultivated from the serum of the bullæ, rod-shaped bacilli, thick, short, and most of them with a clear spherical body upon each, and which is not colored by the fuchsin which does stain the rod-shaped portion. Cultures of this bacillus inoculated upon guinea-pigs yielded no results.

Cultures from bullæ of varicella disclosed the presence of very small micrococci, having no special arrangement.

These also could not be propagated in guinea-pigs.—*Marseille-Médical*, Feb. 30, 1889.

Leconte on Resorcin in Medicine.—In his Paris Thesis, of Feb., 25, 1888, the author points out the applications of resorcin in the therapeutics of the skin. He recommends it in tricophytosis, pemphigus, lepra, varicose and scrofulous ulcers, and cancroid of the face. He praises its action in condylomata and partial or general eczema, not designating the forms of the latter in which the remedy is indicated. He uses 3 % injections in gonorrhœa, which he says are rapidly curative and never badly borne.—*Ann. de Dermat. et de Syph.*, Nov. 25, 1888.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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MEDICINE AND PATHOLOGY.

Féré (C.) on the Arterial Pressure in Epileptic Paroxysms and Fits of Temper.—The author has found an increase of from 200 to 300 grammes in the arterial pressure during the aura of an epileptic attack. This increased pressure continues during the convulsive period, but falls below the normal when the attack has ended. This period of depression lasts from several hours to a day after the attack. After a series of several attacks the depression may amount to 300 to 400 grammes, and may last several days.

Experimentally, he finds that a sudden relief from this high arterial pressure during an attack (by means of a Junod boot, for instance) will stop the attack temporarily.

A sudden fit of anger raises the arterial pressure also 200 to 300 grammes, and this fact shows the necessity of instructing epileptics to avoid such excitement if possible.

These researches have a practical bearing also in the therapeutics of the disease, and explain the action of many abortive remedies already in use.—*Compt. rend. de la Soc. de Biol.*, May 25, 1889.

Ambrose (A.) on Nitrite of Amyl in Epilepsy.—I was called some eighteen months ago to see a patient at some little distance in the middle of the night, and found him just recovering from a fit; in a few minutes he had another. I caused him to inhale nitrite of amyl, with immediate good effect; and left the bottle, one ounce, about half full, with directions that if another fit occurred the inhalation was to be repeated. In two or three hours another fit came on, and owing to some mistake a large teaspoonful was poured down his throat. After an hour the mistake was discovered. I was sent for, and succeeded in getting up a good deal of the amyl nitrite by hypodermic injection of apomorphine. But the point which I wish to emphasize is that the patient, although previously frequently attacked, has not had a fit since.—*Br. Med. Jour.*, Sept. 21, 1889.

Peterson (F.) on Paraplegia from a Gun-Shot Wound of the Skull over the Cortical Leg Centres.—A male of fifty-seven, holding the muzzle of a pistol to the top of his head, shot vertically downward. The bullet entered exactly in the median line, about an inch behind the bregma and seven inches anterior to the occipital protuberance. It became impacted in the bone, splintering the inner table of the skull. Consciousness was lost for a few seconds. The bullet and splintered bone were removed, and the injury found to consist of a laceration of the longitudinal sinus and some wounding of the dura-mater by spicules of bone.

There was retention of urine for a short time, with exaggerated reflexes in the lower extremities, which were both paralyzed. This paralysis gradually improved (at time of writing patient could walk with a cane), the reflexes remaining exaggerated.—*N. Y. Med. Jour.*, Oct. 5, 1889.

Goltz on the Effects of Extirpation of the Cerebral Hemispheres in the Dog.—The author has removed, at two sittings, seven months apart, both cerebral hemispheres of an adult dog, the animal living fifty-one days after the second operation, and then dying of pneumonia pro-

voked by the penetration of foreign bodies into the bronchi.

The author states that the functions of motion and sensibility were preserved, and that sleeping and waking were normal.

Blindness ensued from separation of the optic tract, and the condition of hearing could not be determined. The voice remained normal and expressive. Some consciousness seemed to be retained, as he went out of his box to deposit his excreta.

The dog could not feed himself nor take food given to him, but would swallow what was pushed clear down to the commencement of the œsophagus. It seemed to experience the sensations of hunger and thirst, as it was restless before and quiet after feeding.—*La Tribune Méd.*, June 13, 1889.

Girode (J.) on Hysteria of Toxic Origin.—In THE MEDICAL ANALECTIC for 1888 attention was called to an article by Marie on "Hysteria Produced by Bisulphide of Carbon." This present article deals with cases of hysteria apparently due to several different kinds of poisons.

In the first three cases, lead was the poison—one had left hemiplegia, two right. In two cases, alcohol was the poison—one had an incomplete right and one a partial left hemiplegia.

In two cases the hysteria was associated with syphilis; one had right and one left hemiplegia. In two cases the existence of mercurial poisoning was plain; in two others less distinct, one being malarial, alcoholic, and a morphine eater, the other being syphilitic and broken down by dysentery and scurvy.

In the twelfth case illuminating gas seemed to be the exciting poison.—*La France Méd.*, March 30, 1889.

Girode (J.) on Tabes Dorsalis with Complex Digestive Troubles—Tabetic Salivation.—The patient was a man of fifty, with an ataxia of eighteen years standing. He had a bad attack of typhoid fever at fourteen, committed alcoholic excesses when twenty-three, and had syphilis when thirty.

When first seen in March, 1888, he was in the paralytic and atrophic stage of tabes, with tabetic foot on both sides and frequent gastro-intestinal crises, with gastro-orrhœa and entorrhœa. These attacks commenced in 1886, and were usually ushered in by salivation. This symptom began brusquely, often at night. The saliva pouring out ran back in the throat, penetrating the larynx and waking the patient with violent cough and suffocation. Once established, the sialorrhœa continued, necessitating sleeping in a sitting posture. The hypersecretion was accompanied by a sapid, ill-defined taste, and the mouth had a fetid odor. Six hundred to eight hundred grammes of saliva have been collected in a few hours. It is grayish, extremely viscid, with no special odor, and a feebly alkaline reaction.

The gastric symptoms were violent, vomiting abundance of glairy mucus, containing food or bile, absolute gastric intolerance, very intense pain and burning in the epigastrium and along the œsophagus, anorexia, and ardent thirst. Soon the intestinal symptoms come on: umbilical pain and distension, a sensation of obstruction, absolute constipation, false alarms, and anorectal burning.

Often genito-urinary symptoms are superadded: burning along the urethra, semi-erection, frequent calls to urinate, the urine passing drop by drop.

This sort of attack would last from three to twelve days, and end by a normal evacuation of the bowels and abundant passage of urine. Belladonna had no effect on the sialorrhœa.—*La France Méd.*, Feb. 19, 1889.

A Physiological Study of Absinthe.—As commonly met with, absinthe only contains about thirty minims of essence of absinthe to the litre, the remainder consisting of alcohol together with from sixteen to a hundred drops each of the essence of aniseed and star aniseed, coriander, fennel, peppermint, angelica, hyssop, and mélisse, and the color is given by fresh parsley or nettles. Cadiac and Meunier recently undertook to investigate the action of the various components of the liqueur, in order to ascertain to which of them its peculiarly intoxicating effects were due. They found that hyssop induces epileptiform attacks in ten-grain doses, while fennel induces visual troubles and langour. Poisonous doses of coriander give rise to sudden anæsthesia and muscular convulsions. Mélisse determines a passing stimulation, followed by lassitude and sleepiness. Both varieties of aniseed possess powerfully stimulating properties, with consecutive visual troubles, muscular inco-ordination, and dulness of sensation, with abrogation of the will and heavy sleep. Although not strictly speaking poisonous, aniseed is a violent excitant

of the nerve centres, even in the relatively small quantities contained in the usual allowance of the liqueur. If the dose be increased, epileptiform attacks are induced. A litre of ordinary absinthe only contains about thirty drops of the essence, a dose which, if taken all at once, only gives rise to powerful mental stimulation, increasing the appetite and facilitating digestion. Moreover, it leaves behind it neither depression nor somnolence. The sum total of the effects of the blend is a sensation of comfort and physical and mental activity, followed by lassitude and indisposition to exertion, and in large doses, to epileptiform attacks. The authors are disposed to attribute the major part of the injurious effects to the collateral essences, and seriously recommend manufacturers to discard the use of several of these, and of aniseed in particular.—*Med. Press*, Sept. 25, 1889.

Bronner (A.) on Pilocarpine in Deafness.—I have used pilocarpine in many cases of deafness, and in some with very good results. At present I have a girl of twelve under treatment who is suffering from a subacute affection of the middle and internal ear. After twenty injections of pilocarpine she can hear the watch with the right ear at twenty inches and with the left at six inches, and hear "whispers" (ninety-nine) at more than five metres with either ear. Before treatment she could not hear the watch at all, not even on contact, and loud speech (ninety-nine) at two metres. There is a history of congenital syphilis.

As far as my experience goes, the following classes of cases seem to be the most suitable for treatment by pilocarpine: 1. Deafness caused by acquired or inherited syphilis, due to changes either in the internal or middle ear. These seem to be the most successful cases. 2. Deafness due to hemorrhage or exudation into the internal ear. 3. Cases of chronic catarrh, with recurrent exacerbations. 4. Cases of sclerosis or dry catarrh, but only in the initial stages. Normal hearing is very rarely restored in this class of cases, but one can frequently arrest the progress of the disease.—*Lancet*, Sept. 28, 1889.

Titus (E. C.) on the Value of Oxygen Combined with Nitrogen Monoxide in the Treatment of Pulmonary and Other Troubles.—The author details four cases in which he has employed this treatment.

One was a man of thirty, with consolidation of the left apex with apparently a small cavity in its upper part; incessant cough profuse muco-purulent expectoration, elevated temperature, night sweats, and rapid emaciation. With the oxygen treatment and the iodide of iron, all symptoms disappeared and had remained away a year.

The second case was also apparently one of phthisis in which all symptoms disappeared except a slight cough, which the author believed was due to pleuritic adhesions. In this case chest expansion increased from 1½ to 3½ inches.

The third case was a woman of twenty-three suffering from an extreme form of simple anæmia, which had resisted all usual remedies and advantageous hygienic conditions. Complete cure resulted in three months.

The fourth case was a man of sixty-three with a bad double pneumonia. The treatment here combined with stimulants and other remedies was eminently successful.

The method of administration is important. The patient should be instructed to expel as completely as possible the air from the lungs, and then inhale deeply, and after fully inflating the lungs it should be held as long as possible before being expired through the nose. There should be an interval of two minutes between each inhalation. This method is applicable to the treatment of phthisis and anæmia. In pneumonia it should be administered continuously from three to five minutes, and as frequently as the urgency of the case demands.—*Med. Record*, Oct. 5, 1889.

Fontan on a New Treatment of Chancroidal Buboes.—The author incises the bubo, evacuates what he can and then injects a certain quantity of hot water, after which he injects melted vaseline, holding a certain quantity of iodoform in suspension. He usually employs a 5 per cent. mixture. An absorbent cotton dressing is applied. The mass solidifies after injection and forms a firm antiseptic plug. Recovery is almost immediate.—*La Tribune Méd.*, April 4, 1889.

Vidal on Hard Chancre of the Lower Lip; Probable Mediate Contagion.—The patient, a woman of twenty-one, had had for three months superficial lesions of the lips. They were covered by yellowish crusts and appeared like an eczema of seborrhœal origin. On subsequent examination it was found that the character of the lesion had changed. It had become

an ulcer with raised edges and a superficial induration of its base. The lip was thickened and the submaxillary lymphatics were enlarged on both sides. Later there appeared a mucous patch on the tonsil and a well-marked roseola. It was ascertained that the patient used the same speaking-tube as a young man in the office who had "something the matter with his lips." If the young woman's story was true, she suffered from a syphilitic lesion engrafted upon an eczematous affection in an entirely innocent manner.—*Ann. de Dermat. et de Syph.*, April 25, 1889.

Fournier on Syphilis Aggravated by Alcoholism.—A woman of twenty-four with a still unhealed ulcerating chancre of the vulva, broke out with an intense eruption which is seldom seen except in the tertiary stage. The eruption was a polymorphous, papular syphilide; there were papular tubercles and tubercular ulcers. She had also syphilides of the mucous membranes, insomnia, headache and analgesic spots. The disease in this instance was aggravated by the abuse of alcohol. The woman was a waitress in a drinking saloon and had for five years drunk to excess, taking daily about thirty glasses of beer, three or four absinths and three to fifteen brandies.—*Ann. de Dermat. et de Syph.*, April 25, 1889.

Eager (W. B.) on Concentrated Lactic Acid as an Escharotic.—It differs in its action from the actual cautery, caustic potash, or its combination with lime, the zinc chloride, or the mineral acids, in that it does not excite inflammation in the adjacent healthy tissue, in this respect resembling more the arsenical paste. It does *not* act as rapidly as the caustics above named, but *does* act quite as efficiently. The author has applied the undiluted acid upon a thin layer of absorbent cotten to the healthy epidermis for several hours without producing excoriation. Unless applied to healthy, denuded tissue, its action is almost painless; applied to a healthy surface, void of epithelium, it causes quite sharp smarting for about a minute, then it soon disappears. The author has used this treatment in epithelioma, lupus exedens, encephaloid cancer, tinea versicolor, and what, for want of a better name, he calls tylosis.

The treatment was successful in all cases, except the encephaloid cancer of the breast. —*Gaillard's Med. Jour.*, Oct., 1889.

Barthélemy on Hereditary Syphilis Transmitted Fourteen Years after Infection.—The writer showed at a clinic a child of four months covered with papular syphilides, some scabbed, some erosive, and others hypertraophic. In spite of the abundant eruption, the general condition of the child was good; there being no osseous or appreciable visceral lesions nor subcutaneous gummas.

The history of the child's parents was interesting, in that it showed that syphilis could be transmitted to offspring fourteen years after the primary lesion. Both parents had had syphilis fourteen years ago. They were married at the age of eighteen. For their disease they were insufficiently and irregularly treated.

For three years they had no children, and then they had a daughter at full term, which died of meningitis at the age of seven years. A second child died the age of seven months with some sort of eruption, and the third at nine months of infantile cholera. The fourth died on the twenty-fifth day, of broncho-pneumonia. The fifth child developed, three days after birth, an interstitial keratitis of the left eye, but lived, remaining small and thin.

The sixth child, the one shown at the clinic, born fourteen years after the parents acquired syphilis, developed, three months after birth, the indubitable lesions already narrated.—*Ann. de Dermat. et de Syph.*, March 25, 1889.

Monteith (J.) on Combinations of Antipyrin and Salicylate of Soda.—During last week I was called upon to visit a patient who was suffering from a rheumatic sore throat and severe pains in the legs, which afterwards proved to be antecedent to an attack of erythema nodosum. To allay the pain I ordered powders containing antipyrin and salicylate of soda. To my astonishment, I found that by the combination of these two drugs a cream resulted after a period of a few hours. Evidently a hygroscopic compound resulted which attracted moisture from the air. Since I discovered the effect of the union of the two drugs I now ordered them in solution. Later I tried to mix antifebrin and salicylate of soda (both white powders), and I found that a pink powder resulted.—*Lancet*, Sept. 28, 1889.

Thornton (D.) on the Treatment of Tuberculous Glands.—A few weeks ago I removed over seventy glands from

one side of the neck of a boy of twelve, and the wound was practically firmly healed in from eight to ten days; they had existed nearly all his life. It is perhaps a matter of opinion and taste as regards the scar. Personally, I think one long clean scar is better than a number of isolated and perhaps puckered ones. At any rate, it should not in these days be a matter of opinion as to the advisability of removing dead and dying glands with the knife or spoon. It is as idle and unsurgical to hide a permanently diseased gland under a poultice or film of iodine paint, and hope that the ordinary pathological laws may be suspended and that the dead gland may mysteriously vanish, as it is to foolishly tinker with an abscess without opening it, in the feeble hope that it may be one of those rare abscesses that are good-natured enough to cure themselves.—*Lancet*, Aug. 31, 1889.

Diday on the Abortive Treatment of Gonorrhœa.—A man of twenty-nine, who had had gonorrhœa three times, contracted it again, and on the second day of the discharge, when all symptoms were well pronounced, went to a drug store, and had put up a 1 to 10 solution of nitrate of silver, which he took home and gave himself as an injection. Of course it caused intense pain, which was somewhat relieved by urinating. In about two hours an abundant discharge came on, serous, with streaks of blood, not purulent, but the color of prune-juice. Intense inflammation of the prepuce, meatus, and urethra of course followed, but three days after the injection all discharge had stopped and all inflammation had disappeared. Thirteen days after the injection the cure remained complete.

A student told Diday that he had used upon himself a 1 to 15 solution with a similar result. The author's solution for aborting gonorrhœa is of the proportion of 2 to 180.—*Ann. de Dermat. et de Syph.*, Jan. 25, 1889.

Northrup (W. P.) on Scorbutus in an Infant.—The patient was a female child, eighteen months of age. One month before death the right leg and knee became swollen and tender. Temperature was 101° F. After two days the symptoms disappeared.

Two weeks before death the child began to seem sick; her gums were swollen and blackened, and bled freely. Two days later her left eyelid became black and swollen; temperature still 101° F. One week before death her pulse became 160 per minute, respirations 50, temperature 103° F., and physical signs of pneumonia developed. At this time her right eyelid showed ecchymosis, and there was marked swelling of the left thigh. During the remaining days of her life her passages became black and pasty; the child was very anæmic, failed rapidly under symptoms of pneumonia, and died. No other ecchymoses were seen, and no evidences of syphilis. Child was wet-nursed the first sixteen months of life, but on account of impaired nutrition was taken from the breast, and was also given vegetable acids.

For a full description of the cases of which this is a typical example, see Eustace Smith's "Diseases of Children."

Autopsy.—Child well nourished. Left thigh symmetrically enlarged and larger than right, though both seemed disproportionately large. Left femur was normal at its upper extremity, epiphysis, and end of shaft; but the lower remaining portion was invested all about with a layer of black clotted blood, having a uniform thickness of 2 to 3 mm. This lay between the bone and its periosteum. The lower epiphysis was separated, and the end of the shaft eroded and softened. A similar dark layer, though less thick, separated the periosteum from the right femur. Right and left tibiæ were surrounded by a thin, dark, hemorrhagic zone beneath the periosteum, and the shafts of these bones at their upper ends and the lower end of the right femur were congested (as seen on section). The fibulæ and bones of the arms and forearms not affected. Brain was normal. Lungs: extensive pleuro-pneumonia of left side, lobar in character—lower and upper lobes; right, extensive bronchitis and scattered masses of hepatization. No hemorrhage in these organs, liver, spleen, nor kidneys.

Microscopic examination of the bone showed no syphilitic lesion to be present, and that the blood zone about the shaft was extravasation, without signs of active inflammation. There was softening and disintegration, but no suppuration in the cancellous bone-tissue. There was moderate congestion at the epiphyseal junctions; in one only was there softening and separation.—*Med. Record*, Sept. 14, 1889.

Besnier (E.) on Purpura Caused by Iodide of Potassium, Not by Iodine.—The author has a patient with an

old syphilis, upon whom the iodide of potassium brings out a purpuric eruption every time the drug is administered. This intolerance was so marked that the author substituted the tincture of iodine in five-drop doses, when the patient developed other symptoms of iodism, dyspnœa, anxiety, and rapid pulse to such an extent that he had to suspend the administration of the drug, although absolutely *no* purpura appeared.—*Ann. de Dermat. et de Syph.*, Jan. 25, 1889.

Comby (G.) on a case of Varicella with a Very Severe Buccal Enanthem.—A girl of four years had been suffering from a generalized varicellar eruption for two or three days.

On examining the mouth the tongue was found smooth and devoid of epithelium, and the seat of fourteen round ulcerations upon its dorsum. They were 2 or 3 mm in diameter, superficial, yellow without inflammatory reaction. The internal face of the lower lip showed three similar ulcerations, and the vault of the palate an equal number. The buccal mucous membrane was red throughout, the saliva abundant and of neutral reaction.

Treatment, consisting in touching, four times daily, each ulcer with a five-per-cent. solution of chlorate of potassium, cured the trouble in three days.—*La France Méd.*, July 25, 1889.

Michel (M.) on a Gangrenous Lipoma.—A mulatto woman, sixty years old, of marked obesity, weight 175 pounds, exhibited general prostration, with persistent anorexia. A tumor, oval in shape, about the size of a large child's head, was attached by a pedicle three inches in length over the supra-spinous fossa and superior border of scapula. It had been growing for five years without pain or inconvenience, until a few weeks previous to admission into hospital, when a small suppurating spot appeared on the summit of the tumor and progressed with rapidity, involving much of the skin and dipping down into the growth to one third of its depths. The odor was intensely repulsive, and the discharge so considerable that constant irrigation with Labarraque's solution was necessary to keep her cleansed—covered with oakum and deodorized with 1–500 solution of permanganate of potash. Under chloroform two eliptical incisions included the pedicle and furnished the necessary flaps; very little hemorrhage; the wound was washed out with 1–2000 bichlor. solution, drainage-tube inserted, and wound closed with interrupted suture. Examination disclosed a true lipoma, invested by a fibrocellular capsule, with septa passing inward, dividing tumor into lobules of various sizes.—*North Carolina Med. Jour.*, Sept., 1889.

Uterine Tuberculosis.—An interesting case of primary tubercular disease of the Fallopian tubes has occurred in Professor Lebedeff's wards. The patient, who was the widow of a man who had died of phthisis, was of a cachectic appearance and suffered from amenorrhœa. On examination, a firm, nodulated, intra-abdominal tumor was made out, situate in the space of Douglas. An attempt was made to remove the tumor, but had to be given up as disseminated miliary tubercle was found affecting the peritoneum. The intestines and the uterine appendages too were all matted together. Six weeks after the attempted operation the patient died with symptoms of general tuberculosis. At the post-mortem examination miliary tuberculosis was found affecting the peritoneum, the lungs, the pleuræ, the colon, and the mucous membrane of the uterus. Both the Fallopian tubes were dilated and filled with pus, the epithelium in parts being absent. The intensity of the destructive process was greatest in the tubes, and became less marked towards the periphery. In sections, tubercle bacilli were found; there was no tuberculosis, however, in the ovaries, and only the mucous membrane of the uterus was affected.—*Lancet*, Sept. 28, 1889.

Leadman (A. D. H.) on Fatal Result of a Wasp Sting.—A farm laborer, aged 28, was standing close to a pond on Thursday, August 29th, when he was stung on the right side of the neck by a wasp. He took no notice of it; but the next day, late in the evening, both sides of his neck began to swell, and on Saturday, the 31st, things looked so serious that I was sent for. I found the neck, cheeks, lower jaw, and even the pectoral muscles attacked with acute cellulitis. Careful inquiry elicited the fact of the wasp sting, and that when he received the lesion he had a boil under his left ear; also that, though a very healthy-looking and well-nourished man, he was sadly troubled with constipation, and a member of a family among whom boils and abscesses were very common—thus evidently showing a natural tendency to

suppurative mischief. The treatment consisted of disinfectants both internally and externally, hot poultices, milk *ad libitum*, stimulants as far as could be tolerated, and plenty of fresh air; but, in spite of all, septicæmia, with violent rigors and delirium, supervened on the sixth day, and he died on the ninth day after the reception of the sting. No abscess formed, but the cervical tissues were very much indurated. August 29th was a very hot day, and, following as it did a period of rainy weather, the conditions were very favorable to the rapid decomposition of dead organic matter, whether animal or vegetable, and it is highly probable the wasp may have been feeding on some putrescent material previous to stinging the unfortunate man. As he had nothing whatever to do with the cattle, and as all the horses and cattle on the farm where he was employed are quite healthy, it is clear this was not a case of anthrax or malignant pustule, but death due to a wasp sting received when the system was not healthy.—*Br. Med. Jour.*, Sept. 21, 1889.

Simond on Leprosy and its Mode of Propagation in French Guiana.—Leprosy was unknown before the invasion by Europeans. The disease exists in all coast towns, especially where the negro element predominates. Negroes have the anæsthetic, mutilating variety; whites the mixed or pure tubercular form. The disease is looked apon as hereditary, and the author cites one case strongly corroborative of that theory. A colored woman had by her first marriage two children which were born and remained healthy. After her husband's death she had by a negro, whose brother and one paternal ancestor were leprous, two children who became leprous. From another illegitimate union she had a daughter whose health, at the age of fourteen, left nothing to be desired. —Bordeaux Thesis in *Ann. de Dermat. et de Syph.*, March 25, 1889.

Bouchard (C.) on the Existence of a Splenic Souffle in Certain Maladies of the Spleen.—During the last three years the author has auscultated the spleen in every case where it was enlarged. Five times he has made out a murmur in the splenic region, a souffle which was not cardiac nor attributable to any neighboring vessel. In three cases the enlarged spleen co-existed with a cirrhosed liver; in one case the enlargement had a leucæmic appearance, although the blood was not leucocythemic; in the last case there was also a large liver in an obese patient. In many cases of splenic enlargement of a malarial or leucocythemic nature, no bruit whatever could be discovered.—*La France Méd.*, March 23, 1889.

Wacquez on Icterus Treated by Rectal Injections of Water.—The first case was a man of 45, who had often suffered from hepatic colic. An attack came on early in December, 1888, characterized by severe right hypochondriac pain, greenish vomiting, and white fetid stools. Icterus with high-colored urine came on. All these symptoms, in spite of treatment, had lasted until Jan. 9th, on which day and on the 10th, three enemas of cold water, a quart each, were given. Immediate improvement ensued and in a few days the digestive troubles disappearing, the urine becoming more abundant and clear, and the icterus gradually fading. The same result followed in a case of catarrhal icterus. —*Jour. des Sci. Méd. de Lille*, May 17, 1889.

Robson (M.) on Cholecystenterostomy for Biliary Fistula.—The patient had had abdominal section performed upon her three times. The first operation was for pyosalphinx, and was performed five years ago. Eighteen months ago the abdomen was again opened for acute peritonitis, with pus in the gall-bladder. The bile finally came away through the wound, and a biliary fistula resulted. From thirty to forty ounces of bile daily escaped on to the surface of the abdomen. To remedy this condition the abdomen was opened again, and the gall-bladder attached to the colon by a double row of sutures; the original opening in the gall-bladder was then sutured. Mr. Robson said he could find no record of a case of biliary fistula previously cured. An operation had been proposed by a German surgeon for a case of obstruction of the common duct, but it was not carried out. He employed Lembert's suture to attach the gall-bladder to the intestine, but the opening in the gall-bladder was closed by a continuous suture. —*Med. Record*, Sept. 14, 1889.

The Native Egyptian as a Subject for Surgical Operation.—The native Egyptian is an extremely good subject for surgical operation. Clot Bey, the founder of modern medicine in Egypt, has it that "it requires as much surgery to kill one Egyptian as seven Europeans. In the na-

tive hospitals, the man whose thigh has been amputated at two o'clock is sitting up and lively at six, and the woman who has had her breast removed for cancer, and her axilla completely dissected out, is walking the corridor next morning." Shock is almost entirely unknown, and dread of an impending operation quite an exception. In explanation may be noted the resignation inculcated by their religion; the very small proportion of meat in, and the total absence of alcohol from, their diet; and in general their regular, abstemious, out-of-door life. —*Br. Med. Jour.*, Sept. 14th.

Walker (B.) on the Co-existence of Diphtheria and Typhoid Fever.—A healthy well-developed housemaid, æt. eighteen, dislocated her shoulder on December 20th, and after reduction, she went into the country to take rest for a few days, living in a cottage provided with defective sanitary arrangements. I was next called on December 24th, and found her in bed complaining of languor, loss of appetite, and pain in the head, throat, and chest; I found the tonsils enlarged, and four pinkish-gray circular raised patches on the right tonsils, and one on the left; the lungs were in the "Stoke's stage" of acute pneumonia, characterized by harshness and roughness of the breath sounds; engorgement had not set in.

The tongue was coated down the middle only, and red at the edges. There was no pain in the abdomen, and the bowels were regular. Urine diminished, and of sp. gr. 10.20, faintly acid, rather dark, with a distinct trace of albumen; temperature 100°. During the next two days the patches on the tonsils extended backwards and forwards, involving the uvula and the buccal mucous membrane, becoming more dense, and of a duller gray color; temperature 99°. The breathing was short and painful; the lungs were engorged, and crepitant râles were general.

The urine became more scanty, with ⅛ albumen, and of a deeper color. Until the eighth day the case continued to give the usual signs and symptoms of diphtheria of a dangerous type. On the ninth day the girl felt quite prostrate; the headache increased, and she complained of pain in the abdomen and loins; this was accompanied by tenderness in those parts on gentle pressure; there was laxness of the bowels, with frequent vomiting, and the patient was in a very bad state.

I examined the skin daily, and on the fourteenth day found several typhoid spots on the abdomen, a few on the chest, and also on the forearms. The condition became more alarming; the breathing was much impeded by the diphtheritic lining of the throat, but on the twenty-third day the abdominal tenderness lessened, the stomach was less irritable, and the day following the patient coughed up a cast of about half the pharynx and that part of buccal mucous membrane on which the gray lining was deposited at the outset; it left a slightly red, raw, bleeding surface. During the next two days, the patch on the other side of her throat was coughed up, and from this time she began to improve slowly, but was unable to feed herself for a fortnight. She was kept in bed a fortnight more, and has since made a good recovery, except that the kidneys have remained weak, and albumen is present in the urine.

The interest in this case is the co-existence of the diseases and the severity of the diphtheria which attacked the girl first. Benzoate of soda, muriate of iron, and tonics were the chief drugs used, with glycerine of tannin for local application.—*Provinc. Med. Jour.*, Oct. 1, 1889.

Murray (W.) on the Removal of Renal Calculi by Toxic Doses of Belladonna.—Mrs. E—— had suffered for several months from repeated attacks of renal colic. During the last of these attacks I was called in, and found her in the agony of a severe attack. Belladonna was administered until decided toxical effects were produced, and the patient was relieved of her sufferings as soon as the drug began to show its physiological action on the eye and throat. It was then pushed until she was fully under its influence, and in a few hours the stone passed into the utensil with the usual satisfactory click—a lithicacid calculus—as large as a small almond.

The next case was that of a young engineer, who had suffered long and severely from renal pain, with occasional attacks of true renal colic. He had been treated by an experienced practitioner without much relief. I advised the administration of forty drops of tincture of belladonna, to be repeated every hour, or every two hours, until dilatation of the pupil, dryness of the throat, and delirium were produced. This treatment was commenced in the after-

noon, and during the night following he passed a calculus as large as a bean. It is to be noted that the treatment gave speedy relief of pain, but not content with this, the effect of the drug was kept up, so as to ensure the passage of the stone.

The third case was that of a youth, who suffered so severely from renal pain, that it was determined to remove the calculus by operation. Before consenting to the operation, his parents brought him to me; I suggested the belladonna treatment, promising to send him to the hospital again if it failed. In this case twenty drops of tincture of belladouna were given at intervals of an hour, and at the end of four or five hours he passed a round and rough calculus, composed of urates.

In the present state of pharmacology we cannot say what its precise mode of action may be. It may act by simply paralyzing the circular muscular fibres of these canals, thus allowing the stone to be washed out by the urine; or while paralyzing the circular fibres it may stimulate the longitudinal fibres. The special point to be remembered is that we are to push the drug to its toxical stage, and keep up its action after the pain has been relieved, until a fair time has been allowed for the expulsion of the stone. We may begin with a forty-drop dose of the tincture, and repeat it every two hours, increasing or diminishing the dose according to its effect on the patient.—*Provinc. Med. Jour.*, Oct. 1, 1889.

Nixon on Arterio-sclerosis; Renal Cirrhosis.—A young married woman, aged thirty-two, was admitted into hospital suffering from extreme gastric irritability, accompanied by hepatic tenderness. There was a history of most intemperate habits. Her parents were also addicted to the use of alcohol. During the course of the case, attacks of diarrhœa set in; the patient became drowsy and delirious; and she died of progressive asthenia about a month after her admission. The urine was examined, but it contained no trace of albumen.

The *post-mortem* examination disclosed a very widespread arterial degeneration, affecting mainly the arteries at the base of the brain and in the spinal cord. The coronary arteries were likewise affected by the atheromatous process, and in connection with this degeneration localized fatty changes were observed in the myocardium. The aortic valves presented evidences of inflammatory thickening, principally starting from the corpus Arantii; they were, however, competent. The interior of the entire of the arch of the aorta and the thoracic aorta was in a condition of atheromatous change. In the abdomen the spleen was found small and dense from increase of trabeculæ. The pancreas was in a condition of marked induration. The kidneys were in an advanced condition of cirrhotic change, the branches of the renal arteries being markedly thickened, and presenting open gaping mouths on section. —*Dub. Jour., Med. Sci.*, Sept., 1889.

Hubbard (J. C.) on a Case of Undescended and Hypertrophied Testicle, with Congenital and Multilocular Hydrocele.—A tall, lean, pale man, æt. 30, subject to cough with physical signs of partial consolidation in the summit of the right lung, gave the history that from infancy his right testicle has been situated in the groin, "just under the skin," and that it was smaller than the opposite one until it became inflamed two years ago. Owing to its abnormal position the gland was frequently subjected to pressure, blows, and consequent pain and tenderness. Two years since it became unusually painful and sensitive to the touch, and began to enlarge after receiving a pretty severe blow. During the few months just passed, the growth of the tumor has been more perceptible, and is a source of annoyance and anxiety. The increasing pain and tenderness have entirely interrupted his business. On inspection an oval-shaped tumor, six and a half inches long and five inches wide at its broadest part presented itself just above the right groin, extending from a point about half an inch to the right corresponding crura of the penis outward and upward toward the anterior superior spinous process of the ilium, occupying and distending the inguinal canal, its lower border slightly overlapping Poupart's ligament. The outer and inner extremities of the tumor were elastic and fluctuating. The central portion was firm and hard, feeling like an enlarged and indurated testicle. The integument had a glossy tense appearance, slightly reddened, and was tender to the touch, but not strictly adherent to the gland. The tumor was as mobile as a non-malignant growth in a like situation could well be. It could be fairly grasped and moved a little in every direction, but could not be elevated from its bed.

The patient was advised to rest in the

recumbent posture; to have leeches applied to the tumor from time to time, to be followed by refrigerant applications till heat and redness abated; and finally ung. iod. pot. co., tonics, wine and full diet. This treatment was begun November 1st, and designed to improve his health; to remove inflammation and induration in the tissues adjacent the tumor, preparatory to extirpation.

On the 17th inst. the man's general and local conditions were so much improved as to sanction the operation. The outer fluctuating extremity of the tumor proved to be a "sacculated arrangement" or multilocular hydrocele, and discharged nearly two ounces of straw-colored serum. The septum of the sac was formed by adhesion of the vaginal tunic of the scrotum to the central surfaces of the testicle. At the inner extremity of the swelling a second sac was opened, which contained similar fluid; it connected with the abdominal cavity through the inguinal canal and internal ring. The testicle had performed the office of valve to the ring, and as soon as the restraining pressure of the integument and superincumbent fascia was removed by incisions, it discharged about thirty ounces of straw-colored serum. The inguinal canal was dilated, constituting in part the basin of the hypertrophied gland. The pillars of the ring were so widely separated, and the intercolumnar fascia so attenuated as not to be noticeable. The internal ring had an open diameter of three or four lines. Its closure had been so effectual from the pressure of the testicle as to prevent not only the egress of any abdominal viscus, but to arrest all impulse from being communicated to the finger placed upon the inner hydrocele when the patient coughed. Thorough pressure upon the sac, the patient being upon his back, did not diminish its size in the least, and prior to the operation it was not supposed to communicate with the peritoneal cavity. On first examination the vas deferens was discovered passing down half way to the bottom of the scrotum, forming a loop. The spermatic cord was only one and three fourths inches in length, large, six or seven lines in diameter, and firmly attached centrally to the posterior border of the testicle, as if it penetrated it rather than being a continuation of the epididymis. It had a fibro muscular appearance, and was perfectly inelastic. On being divided close to the testicle it was seen to be as firmly attached to the gland as if penetrated its fibrous vestment. Inflammation and pressure of the epididymis had probably shrunken and changed its normal characteristics so as to make it hardly recognizable. The vas deferens could not be traced to the epididymis, to the testicle, nor to the cord. After passing down into the scrotum and forming a loop it dissappeared in its upward progress to the side of the testicle. Six small arterial vessels divided with the cord required ligatures. The wound was closed by metallic sutures, gelatine plaster, compress, and bandage. The latter two expedients were designed to prevent hernial protrusion the oozing of the blood and its admission into the peritoneal cavity. Full doses of morphine were directed for the first pain complained of after the anæsthesia should have passed away.—*Toledo Med. and Surg. Reporter*, Sept., 1889.

Senn (N.) on the Healing of Aseptic Bone Cavities by Implantation of Antiseptic Decalcified Bone.—The author thinks that antiseptic decalcified bone is the best substitute for living bone grafts in the restoration of a loss of substance in bone.

In the treatment of bone cavities, antiseptic decalcified bone is preferable to Schede's blood-clot, as it is not only a perfectly aseptic, but at the same time also a strongly antiseptic substance.

Implantation of a disk or plate of antiseptic decalcified bone into a cranial defect may be relied upon as a hæmostatic measure in arresting bleeding from the vessels of the diploë, it constitutes a good temporary substitute for the lost portion of the cranium, it prevents the direct union of the brain or its envelopes with the pericranium, and, finally, it furnishes the most favorable condition for the production of new bone from the margins and the closure of the remaining defect by a firm and unyielding membrane.

The packing of an aseptic bone cavity with chips of antiseptic decalcified bone guards against unnecessary loss of blood and exerts a potent influence in the prevention of infection by pus microbes that might have remained upon the surface of the wound or in the tissues.

Capillary drainage by an absorbable drain should be established after implantation for the purpose of preventing the accumulation

of more blood in the wound than is necessary to form a temporary cement substance between the bone chips and between the contents of the cavity and the surrounding tissues.

In the treatment of an aseptic bone cavity by implantation of chips of antiseptic decalcified bone, the packing answers the purpose of an antiseptic tampon, and furnishes the best medium for the growth and development of the tissue resulting from the regenerative process initiated by the trauma.

Secondary implantation can be successfully practised in the treatment of a suppurating bone cavity after suppuration has ceased, and the cavity can be transformed into the same favorable conditions for healing as an aseptic wound.—*Am. Jour. Med. Sci.*, Sept., 1889.

Marcy (H. O.) on the Cure of Hemorrhoids by Excision, and Closure with the Buried Animal Suture.—The method practised by the author was a modification of Whitehead's, which, he says, is a distinct advance over procedures previously discussed. Among the conclusions were: 1. That the ligation of tissues for the purpose of producing necrosis, and resulting antiseptic decomposition, should to-day be considered unsurgical, and never to be resorted to in any part of the body. 2. The destruction of tissue by the actual cautery was provocative of pain and suffering, and was unwarranted in that it was unnecessary, with rare exceptions, in surgery. 3. The dissection and removal of the hemorrhoidal plexus of diseased vessels was as rational and scientific as the dissection and removal of diseased tissues elsewhere; that the danger of hemorrhage from excision of these structures had been greatly exaggerated. 4. That by the method which he (Dr. Marcy) practised, the operation could in no sense be considered a bloody one; it was simple and easy to do after a little experience; there was no material hemorrhage, the important blood-vessels being secured before division by continuous encircling sutures, which served still further the purpose of holding at rest the divided tissues. Necrosis of the parts was entirely avoided, and with the care practised in modern antiseptic surgery the wound was maintained aseptic. The superficial tissues were accurately coaptated, so that no stitch acted as a foreign body. He used animal sutures altogether, that from the tail of the kangaroo, the fascia latæ of the moose, or possibly that of the buffalo, although this could scarcely be obtained on account of extinction of the animal. The advantages of the buried suture over the excision method of Dr. Whitehead were: It secured constriction of the blood-vessels before division; more accurate readjustment and closure of the parts through continuous sutures which were buried and incorporated in the tissues. The time required in the use of interrupted sutures was longer. —*Med. Record*, Oct. 5, 1889.

Lucas (R. C.) on a Case of Necrosis of the Alveolar Processes Following Measles.—The cases of acute disease which are treated by physicians not unfrequently leave local weaknesses and degenerate tendencies, which fall, perhaps months afterwards, to the charge of the surgeon. These local affections may in many cases be regarded as direct sequelæ of the acute disease, and particular exanthemata seem prone to produce necrosis in particular situations. The rib necrosis and tibial nodes which may follow typhoid fever are not, so far as I am aware, often found as a result of measles or scarlet fever, nor do I know of any case of typhoid fever which resulted in exfoliation of the alveolar processes of the jaws. The following case of alveolar necrosis I have thought well to placé on record.

J. B——, aged three, was admitted into Guy's Hospital, under my care, on July 31, 1889, and the report is from notes taken by Mr. Sydney T. Roberts. There was a healthy family history. Five weeks before admission the child suffered from measles and inflammation of the lungs. He was much convulsed during the attack. The illness lasted about a fortnight, but the mother noticed after his recovery that there was something wrong about his mouth. When admitted the child had a fairly healthy appearance. There was a little breaking out about his lips, his mouth was very foul, and the breath extremely fetid. On the front of both the upper and lower maxillæ, and limited to the anterior or central parts of both alveoli, was a green-black portion of necrosed bone. That on the upper jaw was quite loose, whilst that on the lower appeared still firmly attached. The disease appeared confined to the alveolar processes. The four incisor teeth had dropped out from the necrosed process of the upper jaw. In the lower jaw the

necrosis, besides involving all the incisor sockets, included those of the two canines. On July 2d, the patient being placed under chloroform, I removed with forceps the necrosed portion of the upper jaw. It came away with great ease. There was more difficulty with the alveolus of the lower jaw, and it became necessary to use a stronger forceps. The piece removed from the upper jaw was nearly quadrilateral, measuring three-quarters of an inch both vertically and transversely, and it contained the sockets of the four incisor teeth. The portion removed from the lower jaw was rather larger. It contained all the incisor sockets, together with half the socket of the canine tooth of the right side, and the whole socket of the corresponding tooth on the left side. The mouth was well washed out with Condy's fluid, and iodoform applied. On July 3d, the patient's mouth was in a much healthier condition, and the fetor much diminished. On the 5th the patient's general health was improved, and the condition of the mouth much sweeter. On the 7th the patient was discharged convalescent.—*Lancet*, Oct. 5, 1889.

Kelsey (C. B.) on an Unfortunate Result of Whitehead's Operation for Hemorrhoids. — The following case is that of a patient brought to me a few days since by Dr. Peckham:

A woman, aged thirty-five, was operated upon eight months since in one of our city hospitals for hemorrhoids by Whitehead's method. "The operation had never healed."

On examination, the anus presents a circle of excoriated mucous membrane ending suddenly in healthy skin. The mucous membrane, which has been drawn outside of the rectum and united to healthy skin, is an inch broad for one half of the circumference of the anus and half an inch broad for the remainder. In other words, the circular incision in the operation was entirely outside the margin of the anus, and the mucous membrane has been drawn down to it, changing a muco-cutaneous opening into one covered by mucous membrane.

The plan of treatment advised was to dissect this mucous membrane loose, cut it off, bring the skin up as near the verge of the anus as possible, and allow the wound to heal by granulation. A stricture of the anus would, of course, be the natural consequence, but one which I think could be managed and would be better than the extensive ulceration which is sure to follow the excoriation now began. It is needless to say that the patient's present condition is a very miserable one.—*N. Y. Med. Jour.*, Oct. 5, 1889.

Pathology of Severe Burns.—Dr. Oscar Silbermann of Breslau, studying the clinical and pathological signs of the destruction of numerous red-blood corpuscles, found by his experiments: 1. That after extensive burns of the skin the red-blood corpuscles alter their form and lose their power of resistance to heat, drying, compression, and staining. 2. In consequence of these alterations numerous thromboses in the arterioles and capillaries, especially in the finer branches of the pulmonary artery, occur, leading to stasis in different organs—*e.g.*, lungs, kidneys, stomach, bowels, liver, spleen, skin, and brain. 3. The large deviation of the pulmonary capillary circulation produces a considerable impediment to the emptying of the right heart and serious venous congestion, as well as dangerous arterial anæmia. 4. This state, coupled with the above-mentioned symptoms, leads to bleeding and parenchymatous alterations in the affected organs. 5. The interference with the circulation also produces dyspnœa, a small pulse, angina, eclampsia, and anuria, as well as a remarkably low temperature.—*Lancet*, Sept. 28, 1889.

Smith (A. H.) on a Case of Periodical Engorgement of the Liver.—In a woman of 26 five successive menstrual periods were replaced by five attacks of hepatic enlargement with acute inflammatory symptoms. From the first of these attacks the recovery was complete; from the fourth it was only partial; and the fifth attack proved fatal.

At the autopsy the liver was seen to be enlarged and adherent to the surrounding parts. Its surface was slightly roughened and dotted with yellow nodules and small red and black spots; its cut section presented much the same appearance. The spleen was enlarged and contained numbers of cheesy nodules. The left ovary contained a Graafian follicle filled with blood. On microscopical examination the liver and spleen were seen to contain spots of congestion and hemorrhage, and also small areas of granular matter without visible structure, which were apparently necrotic. There were also numerous collections of abnormal cells, mostly of large spindle-cells with many giant-cells, which resembled sarcoma.—*Med. Record*, Oct. 12, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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THERAPEUTICS.

Chloralamide: A New Hypnotic.—Chloralamide, the latest hypnotic discovered by Mering, consists of colorless crystals soluble in 9 parts of water and 1½ parts of strong alcohol; possesses a bitter but not unpleasant taste. Both aqueous and alcoholic solutions are unchanged by keeping and by weak acids, whilst by calcium oxide they are quickly, and by the alkaline carbonates slowly, decomposed. The melting point of the crystals is 115° C. Experiments on dogs showed that the drug produced no deleterious effect upon the circulation. In artificial digestion slight retardation occurred.

The conclusions drawn by Halasz[1] from 194 administrations of the drug in 31 different patients—affected with insomnia from cardiac trouble, phthisis, neuralgia, bronchitis, emphysema, disease of the spinal cord, and of the stomach, chronic alcoholism, etc.—are as follows:

That chloralamide is a good hypnotic, but not absolutely certain in its effect. The dose is from 2–3 grms. It is seldom of use where the insomnia is dependent upon pain or cough. It has no bad effect upon the heart or circulation, and may be administered with safety in valvular lesions, cardiac weakness, and arythmia. It is not free of after-effects; in many cases headache, and in some dizziness, weakness, and dryness of the throat, and in a few vomiting following its administration. A cumulative effect was not noticed, nor was any tendency to the formation of a habit observed.

Alt[2] has also given the results of his experience with the drug. On the heart and pulse no effect, even in doses of 4 grms In four healthy persons, in order to test the effect on digestion, he gave from 3–4 grms., together with a test meal, and found after 3½ hours that digestion had proceeded normally and no unpleasant effects were observed on the part of the stomach. Four grms. given to two healthy women produced in both an hour after administration dizziness and hebetude, and in one there was soon added a condition resembling intoxication with excitement and unceasing talkativeness, whilst the other complained of giddiness and reeling, headache, especially in the occipital region, with nausea and vomiting. Washing out the stomach of the last-mentioned woman showed it to be empty, and the vomiting did not cease even after this procedure. There was no change in the pulse outside of a slight increase in frequency.

The drug was administered to 41 persons suffering from insomnia due to different causes, 196 doses being given, and he concludes from the results of these observations that in many cases it causes sleep, especially in simple insomnia, and exerts no bad effects either on the circulation, respiration, or digestion, and gives rise to relatively few unpleasant effects, and on account of its taste is preferable to amylen hydrate. In the 41 cases 12 times there was no hypnotic effect obtained from the

[1] *Wiener medicinische Wochenschrift*, 1889, No. 37–38.

[2] *Berliner klinische Wochenschrift*, 1889, No. 36.

administration; headache and hebetude in 11 cases were the only unpleasant effects noted. Sleep was produced from ½ to 1½ hours after administration and lasted from 3 to 9 hours. Its sedative effect in small repeated doses was shown in three cases —one of well-marked delirium tremens, another of an excited hypochondriacal patient, and a third of a restless, nervous patient with hallucinations. In four other cases it failed completely. In a well-marked case of chorea in a lad 11 years of age, five days' use of the drug in doses of 1 grain three times a day resulted in an almost complete cessation of the choreic movements, and eight days' use in a similar case in a girl who had been treated for 14 weeks with arsenic without effect, gave a similar result. W. V.

Chloramid.—Chloramid, another new hypnotic, has now been extensively tested, as the literature of the subject sufficiently shows. From its composition one would beforehand expect it to have many of the properties of chloral hydrate. It is a combination of chloral with formamid, and forty-five grains of chloramid correspond to thirty grains of chloral hydrate, not by any means an insignificant dose even if the formamid were omitted. It causes sleep in doses of from one to four grammes, not so quickly as chloral hydrate, and in less time than sulphonal. Professor Rabow, writing in *Erlenmeyer's Cbl.*, has not been able to form an opinion as to its action on the vascular system. It had so far shown no disagreeable after-effect as sulphonal has done. It was quite readily taken in tea, wine, and egg. In delirium and in patients much excited it produced no effect in doses of from three to four grammes. It was effective, on the other hand, in the great majority of cases of insomnia from abuse of alcoholics, and also in so-called nervous sleeplessness, neurasthenia, etc.

Prof. Mosler's assistant, Dr. Peiper, of Greifswald, has also communicated his observations to the *D. med. Wochenschr.*, 32, 1889. Two to three grammes were sufficient to procure sleep. In women two grammes were generally sufficient, and in the case of a little girl 0.5 gramme produced sleep lasting three hours. The time of the onset of sleep was various, from half an hour to an hour and a half. In the majority of cases the sleep lasted the whole night through. In others there were interruptions more or less short. No special effect was observed on the appetite, intestinal activity, perspiration, or cough. The feeling of thirst in the morning was increased. On the whole, its best action was produced in nervous agrypnia, in the sleeplessness of spinal affections, bronchial asthma, sub-acute rheumatism, and gastric affections in which pain was not a very prominent symptom. Headache, giddiness, and a tired feeling were present in several patients the day after the nightly dose, but the troubles were not severe. In the cases in which a comparison was made with chloral hydrate it was in favor of chloramid. Dr. King, of Strassburg (*Therap. Monats.*, 8, 1889), thinks it superior to either chloral hydrate or sulphonal. Dr. Reichmann, who tried it in Prof. Rugel's klinik, thinks it answers all the requirements of a good hypnotic. In Prof. Strümpell's klinik in Erlangen, in twenty-eight cases the effects were good, in forty-two excellent. In cardiac asthma it appeared to have a specific effect. In organic diseases of the nerves, heart, lungs, and kidneys, it did good service. Two to three grammes are the proper dose. Tried in fifteen cases in Bonn (Hagemann and Strauss), the effects were good on the whole. Sometimes one gramme sufficed, but in some as much as four grammes failed completely to produce sleep. Taken as a whole, however, the observations have been very favorable. —*Med. Press*, Sept. 25, 1889.

Christopher (W. S.) on the Chemistry of Hypnotics and Anæsthetics.—As the author says, in their chemical features, the substances used as hypnotics and as anæsthetics are very closely related. They are all derivations of Marsh gas. This substance, known chemically as methane, has the formula CH_4.

Marsh gas derivatives having more or less marked hypnotic or anæsthetic properties, are as follows:

Monochlormethane,	CH_3Cl	
Dichlormethane,	CH_2Cl_2	Methylene bichloride.
Trichlormethane,	$CH.Cl_3$	Chloroform.
Tetrachlormethane,	CCl_4	
Tri-iodomethane,	$CH.I_3$	Iodoform.
Ethyl bromide,	$C_2H_5.Br$	
Ethyl iodide,	$C_2H_5.I$	
Ethyl hydrate,	$C_2H_5.HO$	Alcohol.
Ethyl oxide,	$(C_2H_5)_2O$	Ether.
Methylethyl ether,	$CH_3.C_2H_5.O$	
Aldehyde,	$CH_3.COH$	
Paraldehyde,	$(CH_3.COH)_3$	

Trichloraldehyde, CCl_3COH Chloral.
Tribromaldehyde, $CBr_3.COH$ Bromal.
Acetone, $CH_3 \diagdown CO \diagup CH_3$
Hypnone, $CH_3 \diagdown CO \diagup C_6H_5$
Sulfonal, $CH_3 \diagdown C \diagup SO_2.C_2H_5 \diagup CH_3 \diagdown SO_2.C_2H_5$
Methylal, $CH_2 \diagdown O.CH_3 \diagup O.CH_3$
Amylen hydrate, $CH_3 \diagdown C(OH) \diagup C_2H_5$
Urethane, $NH_2 \diagdown C=O \diagup C_2H_5.O$.

—*Cincinnati Lancet-Clinic*, Oct. 5, 1889.

Chloroform as an Anæsthetic.—In the medical journals for the last ten years there are reported one hundred and twenty (if not more) cases of death under chloroform. Many of these are very imperfectly described, but in at least forty-nine cases the patients were in good general health at the time of administration, and required an anæsthetic merely for the performance of some minor operation, *e. g.*, extraction of teeth (eleven cases of death), reduction of dislocations (nine cases), eye operations, fistulæ, and so on. In some fifty-nine cases death occurred before the commencement of the operation, and so was clearly due to the chloroform alone. In about twenty of the cases it is noted that chloroform had been successfully given on previous occasions; in one, as many as eight different times before the fatal administration. It is evident from the foregoing that chloroform is uncertain in its action; that not only do people die while *under* chloroform, but also *from* it—frequently, too, even when it is used by skilful hands. Of course it is possible to retort that "it was not properly given," which may be correct. This will not alter the fact that these accidents prove chloroform to be a powerful agent, very difficult to administer properly—indeed, so difficult and dangerous that it is scarcely suitable for a routine anæsthetic, when a drug less powerful for evil can replace it.

The "nauseous flavor" and "the sense of suffocation" from ether can be entirely done away with by the use of nitrous oxide, and its inhalation made more agreeable than even that of chloroform, while the patient quickly becomes unconscious without the struggling so common with chloroform. I have not yet found a single patient who has once inhaled ether preceded by nitrous oxide complain of suffocation or object to take it again on the ground of its unpleasantness.

The readiness with which chloroform affects the heart, the smallness of a fatal dose, and especially the ease and suddenness with which such a dose can be inhaled almost by a couple of deep inspirations, will make its safe exhibition always a difficult task to invariably accomplish. Having had many years' experience, I have gradually come to believe chloroform to be a less safe anæsthetic than ether.—*Lancet*, Sept. 14, 1889.

Ferrand on Some of the Incompatibilities of Antipyrin.—The author has noticed that in mixtures containing antipyrin and extract of quinquina, all the active principles of the mixture are precipitated at once, and that there remained in the filtered liquor only just perceptible traces of antipyrin and the alkaloids. A weak acid dissolves this precipitate. The author thinks that this change does not render the mixture inert, as the acid of the gastric juice probably dissolves the active principles.

Blainville, a pharmacist of Paris, on mixing a drachm of antipyrin and gr. lxxv. of chloral hydrate in ʒ ss. of water, noticed that the liquor took on a milky aspect, which cleared up with the settling to the bottom of an oily liquid. When decanted, the liquor possessed the taste neither of chloral nor antipyrin, but rather that of coriander seeds. The author cautions physicians and druggists against using antipyrin in complex mixtures until its chemical characters are more fully determined. —*L'Année Méd.*, Sept. 15, 1889.

Anderson (E.) on an Eruption from Iodine.—Some years ago I was treating, for an eruption, a woman who told me never to touch her with the tincture of iodine, as it was sure to bring on an attack of erysipelas; I did not use it in her case, but by mistake she used some that was left for her sister, and, sure enough, it brought on a severe attack of the before-mentioned disease. I afterwards prescribed the iodide of potassium in five-grain doses, and after taking one dose she broke out just as she had done from the local application of the tincture of iodine.—*Maryland Med. Jour.*, Oct. 12, 1889.

Stuver (E.) on White Lead in the Treatment of Erysipelas.—The author simply paints the erysipelatous part with

white paint made with white lead, and believes it more efficacious than any other application.

He says it promptly relieves local pain and tenderness, limits the spread of the disease, and, by forming an impermeable covering, it prevents dissemination of the disease germs, and, consequently, infection of abraded or wound surfaces. He cites its use in four successful cases, and as one was a puerperal woman, his results are remarkable. In some, perhaps all, of the cases, quinine and iron were given internally.—*Med. News*, Oct. 5, 1889.

Marquis (M. V. C.) on Antipyrin in Cancer of the Cervix Uteri.—I have found that antipyrin admirably subdues the pain immediately after its administration in a case of cancer of the cervix uteri; though this beneficial effect was of short duration, still it was of great importance and satisfaction to the patient. Being summoned to see a woman of 40, I found her suffering from cancer of the cervix uteri in an advanced stage. She complained of severe lancinating pain, worse at night, disturbing sleep, and of intense fœtor of the discharge, and of many other things. She also stated that, having consulted with several other physicians, she had obtained no relief. The characteristic severity of the pain and fœtor of the discharge had reduced the patient to a pitiable condition. It occurred to me that antipyrin perhaps would do her some good, so forthwith I prescribed ten grains of it to be given at once in my presence; and great was my surprise, still greater being the satisfaction of the patient, to see the pain, which was so severe just before, stopped altogether immediately. Now I repeat the same when the pain comes on, and have seen no unpleasant symptoms arising attributed to antipyrin.—*Br. Med. Jour.*, Sept. 21, 1889.

Chorea Attributed to Poisoning by Iodoform.—The twenty-fifth annual report of the Jenner Hospital for Children in Berne contains a report of a secondary retro-pharyngeal abscess in a boy of six years, who was suffering from disease of the cervical vertebræ. Professor R. Demme opened this abscess, and a second, which had reached to the middle of the right clavicle. A little iodoform bougie was introduced in the fistulous canal, and the wound dressed with iodoform powder and gauze. Three days afterwards the boy suffered from headache and complained of being sick, but the dressing was not changed, and a second iodoform bougie was introduced four days later, when convulsions began to occur gradually, passing on to chorea. The iodoform was then omitted from the dressing, and the chorea disappeared after a fortnight. A few weeks later another practitioner dressed the same case with iodol and iodol gauze, and again chorea appeared, lasting for three weeks.—*Lancet*, Sept. 21, 1889.

Kloman (W. C.) on Unusual Symptoms from the Local Use of Iodoform.—The writer applied 30 or 40 grains of iodoform to some large, indolent, and painful varicose ulcers of the leg in an otherwise healthy man. In a few hours intense pain set in with a pulse of 120, hot skin and chilly sensations. There was an intense dermatitis of the leg with numerous large blebs. The iodoform was washed off, the leg dusted with oxide of zinc, and morphine, with atropine, given hypodermatically. The next day there was general malaise, coated tongue, copious diarrhœa, and the whole surface of the body was scarlet with a tendency to peel in furfuraceous scales. The leg was much swollen, as were the hands to such an extent that they could not be closed. He recovered in four days.—*Maryland Med. Jour.*, Sept. 21, 1889.

Nicolson (W. P.) on Carbolic Acid Injections for Radical Cure of Hydrocele.—The operation is performed by throwing the acid through the canula in the ordinary way, care being taken to keep it from escaping into the wound or upon the scrotum. In small hydroceles the fluid may be evacuated with a hypodermic syringe, and the acid introduced through the same needle. In large sacs the method recommended by Dr. Keyes may be adopted. He first introduces the needle of a hypodermic syringe, and then, having evacuated the fluid with a trochar and canula, throws in the acid with the hypodermic syringe. This seems to me to be the most desirable method of operating, and in future I shall adopt it.

The claims made for the carbolic-acid treatment are the great certainty of its action, combined with entire freedom from pain, and much less violent reaction than iodine. It is hard to make one credit the statement that the injection of a fluid drachm of liquefied acid into the tunica vaginalis is absolutely painless, but such is

the fact. There is a moment (perhaps a second or two) of stinging pain, and then it is over. In only one case have I seen a violent reaction; and, as will be seen later, that was brought on by imprudence. As regards the certainty of the result, I have seen a cure when other means had failed; and my only failure was when not enough acid was used.—*Va. Med. Mo.*, Sept., 1889.

Shoemaker (J. V.) on Ten Cases Illustrating the Value of Geranium Maculatum.—The author two years ago called attention to the value of geranium maculatum as a general astringent and hæmostatic.

The cases he now reports are as follows: Three cases of incipient phthisis, two of which the author considers cured. In these cases he generally gave teaspoonful doses of the fluid extract three or four times. In another case, where hæmoptysis had lasted off and on for a week, it being a second attack, a commencing dose of two teaspoonfuls, followed at frequent intervals by half that dose for two weeks, gave relief, and good health continued for over a year. The fifth case was a young woman of twenty-one, with gastric ulcer and vomiting of blood, completely relieved. Local applications of a 25 per cent. solution cured an anal fissure, the sixth case. An injection of a 1-4solution checked a urethral hemorrhage. Intra-uterine injections of a 7 per cent. solution stopped a metrorrhagia, the eighth case, while the last two cases were those of buccal ulceration in which a 20 to 25 per cent. solution was promptly curative.—*Atlanta Med. and Surg. Jour.*, Oct., 1889.

Rively (M.) on Sulpho-Carbolate of Zinc in Diarrhœa.—A child of eighteen months had been suffering from a severe attack of summer diarrhœa for ten days. He had fallen away to almost a shadow of his former self; his features were pinched, and he suffered severe pain with every movement from the bowels, which movements occurred once or twice every hour, day and night. The evacuations were of a very offensive odor, and at times contained a little blood. He was unable to retain any thing on the stomach; not even milk and lime-water, or any prepared food, of which latter his nurse had tried many varieties. I immediately placed the little one on half-grain doses of the sulpho-carbolate of zinc in combination with one grain of the subnitrate of bismuth, every hour, until improvement should be manifest. This course was continued until eight powders were taken, when the improvement was so marked that we dropped down to one dose every two hours, and, in twenty-four hours more, the child seemed like a different being—diarrhœa thoroughly under control, no vomiting, and but slight pain. This rapid improvement continued, until, at the end of three days more, I dismissed the case. Of course, the feeding was carefully regulated, but it was also attended to with much intelligence by my predecessor.

My second case was that of a young lady whom I saw five days later (August 10th), who was suffering from subacute ileo-colitis. Her I placed on three-grain doses of sulpho-carbolate of zinc in combination with an equal quantity of subnitrate of bismuth and one grain of bicarbonate of soda every two hours. The recovery was prompt and permanent. Since then I have had a few more cases, mostly young children of poor parents, whom I was happy to treat, rather as affording material for observing the action of the drug than as a matter of business, and I can heartily testify to its decided therapeutic value, when applied to the class of cases in which a powerful yet harmless agent is required to bring about a comparatively aseptic condition in the intestinal tract.—*Times and Register*, Sept. 21, 1889.

Watson (W. P.) on the Value of Creasote in Fifty Cases of Disease of the Air-Passages.—From a study of fifty cases the author takes a rather rosy view of the healing powers of creasote, as the accompanying summary will show.

Of the above unselected fifty cases of disease of the air-passages, eight were in the last stage of consumption; and while improvement was noticed for a few days after the creasote treatment was used, yet it had no permanent effect.

Of the sixteen cases with simple consolidation, the improvement was so marked in all cases but two (one complicated with chronic Bright's disease and one with consolidation at both apices), that they were discharged from the hospital.

Of the six cases of chronic bronchitis, some with emphysema, others with pleural thickening, all were markedly improved by the treatment.

Of the five cases of acute bronchitis, all were rapidly cured.

The case of acute pleuritis, with effusion, was quickly cured.

The cases of laryngeal phthisis were improved.

The case of acute laryngitis was cured by the inhalations alone.

The cases of nasal catarrh, as a complication, were quickly cured.

The conclusions to be drawn from the foregoing report of cases are, that while creasote will not cure all cases of consumption, yet it will benefit nearly all; that in cases with simple consolidation before the "breaking-down" process begins, it seems to arrest the diseased process, and further investigations will be required to ascertain its permanent utility, although similar cases observed for a long time by Robinson and Flint would convince us that the improvement was lasting.

In acute and chronic diseases of the bronchi, its use was very marked, cases of the former being quickly cured, while those of the latter were improved sufficiently for them to leave the hospital in a short time. Another very important fact noticed in these experiments was that the more constantly the inhaler was worn, and the internal mixture taken, the more marked was the improvement; so that I am satisfied that, to obtain the full benefits of this treatment, the system should be saturated with creasote as rapidly as possible; and while I should not expect any miraculous cures, yet I believe it is, combined with good hygienic and dietetic surroundings, the most promising treatment of consumption in the laboring classes we yet possess.—*Va. Med. Mo.*, Oct., 1889.

Thomas (J. E.) on a Method of Artificial Respiration.—Have the patient in position as for Sylvester's method, with operator at patient's head, and with each hand spread out on patient's chest; hook the fingers under the margin of the ribs, and make firm traction upward and onward, which will produce a deep inspiration; then, with firm pressure downward and inward, expiration is produced.—*Daniels' Tex. Med. Jour.*, Aug., 1889.

Duke (A.) on the Mechanical Treatment of Amenorrhœa.—The mechanical treatment of amenorrhœa by the introduction of an intra-uterine stem to be worn for some time is frequently followed by the desired result. The danger, however, of uterine stems compels the practitioner to enforce the recumbent position on the patient; and as this becomes exceedingly irksome, more especially in the case of younger patients, sufficient time is seldom allowed to effect the looked-for result. A uterine stem to be worn with comfort should be flexible, hollow, freely movable, and require no vaginal support in addition. It should also permit of the patient going about as usual, the exercise contributing in no small degree to the action of the stem. The making of such a stem self-retaining has been the great difficulty met with, as the various modifications of the instrument will testify. With regard to the advantages of the galvanic stem, I have strong doubts as to its action. I have given it a trial on several occasions, and am fully persuaded that a foreign body of *any kind* introduced into the uterine cavity will act quite as well. The stem I recommend is formed of spiral wire (plated), which I originally designed for the purpose of keeping the os and cervical canal patulous after the operation of division of the cervix for stenosis, and it has given me every satisfaction. These stems are made in various sizes, so that if a proper size be chosen and introduced, the patient can go about as usual, and be quite unconscious of wearing such. Indeed, on one occasion I introduced one of my stems without the patient's knowledge, and was rewarded by the menstrual flow being established, which had been in abeyance for over a year. It must be distinctly understood that I do not advocate the indiscriminate use of the stem as a routine treatment for amenorrhœa, but only in those cases where the usual plans of treatment by medicine, etc., have failed, and where the symptoms complained of are such as fully to warrant mechanical interference. The stem should be introduced to its full length, and I have found that the spring introducer lately designed by me is the best instrument for placing the stem *in situ*. The base of the stem being flat and very light, the vaginal walls embrace it closely and in such a manner as effectually to prevent its falling out. —*Lancet*, Sept. 21, 1889.

Death from Sublimate Irrigation after Abortion.—Seven years since, Tarnier introduced the practice of washing out the vagina with weak corrosive-sublimate injections. The results proved satisfactory, and the injections came into vogue in German and English, as well as in French, lying-in hospitals, extending freely into private practice. Like every thorough method of counteracting deadly agencies

in the human organism, sublimate irrigation is not free from danger, and although it greatly reduces the death-rate and proportion of puerperal fever cases in long series of labors, some cases of mercurial poisoning will occur in those series, notwithstanding the most careful administration of the remedy. Dr. Legrand read before the Anatomical Society of Paris, in April, a case of twin abortion, retained placenta, and death from acute mercurialism. Between the birth of the first and second child, 10 litres of a 1 in 2,000 solution of sublimate were employed to wash out the uterine cavity, twice at an interval of three hours only. Immediately after each injection of sublimate a 2 per cent. solution of boracic acid was thrown up into the uterine cavity; but sublimate had been several times employed for vaginal injection. After the extraction of the second child the boracic solution was injected into the uterine cavity. The intra-uterine injections were discontinued, and boracic and carbolic solutions were used for the vagina. A day later gingivitis, salivation, colic, and dysentery set in, and carried off the patient in five days. The kidneys were large, pale, and very œdematous: they contained mercurial salts in solution. The palate was ulcerated; the œsophagus, stomach, and small intestine healthy. The mucous membrane of the entire large intestine was covered with eschars and ulcers, most marked on the summits of the rugæ. The ulcers began in the cæcum, were least abundant in the transverse colon, and most marked towards the anus. The above conditions have been noted in many other cases of death after sublimate irrigations in childbed. The kidneys were diseased. Keller, of Berne, has already pointed out the danger of mercurial irrigation when these organs are not healthy. The English authorities just quoted both dwell on this danger. Dr. Legrand relates that the ulcerated intestinal mucosa swarmed with bacteria. This fact, he adds, must make us despair of securing intestinal antisepsis by means of corrosive sublimate.—*Br. Med. Jour.*, Sept. 28, 1889.

Eccles (A. S.) on the Influence of Massage on the Rate of Absorption from Intestine.—The author is persuaded that carefully regulated manipulation of the abdomen, modified in force, frequency, and duration to meet the requirements of each individual case, is one of the most effectual means of treatment, frequently the only efficacious therapy, in many cases of enfeebled assimilation. He has had opportunities of proving its value in cases of sprue, chronic dysentery, tropical diarrhœa, muscular atony of the stomach and intestines, and various forms of cachexia in which the gastro-intestinal tract has suffered in common with the other tissues. In some of these cases the salol test has been applied to control and verify the results attributed to the use of massage, and its efficacy in increasing the absorption of the contents of the intestine has been established.—*Practitioner*, Oct., 1889.

Andrews (E.) on Painful Muscular Spasms after Fracture Perfectly Controlled by Sulfonal.—In three cases of fracture I have given sulfonal in doses of 15 grains, repeated if necessary, say once in four to six hours. In each case the medicine has stopped the spasmodic twitches completely, giving the patient a wonderful relief. If further experience confirms this result, sulfonal will be a great boon to surgeons and to their patients.

There are other varieties of reflex spasm which may perhaps be relieved by the same remedy. For instance, in hip disease, the inflamed head of the femur provokes frequent nocturnal spasms of the adjacent muscles, causing the patient to awake with a scream. Extension apparatus generally controls this, but in many instances an adjuvant is needed for a time, and sulfonal may prove to be as effective for this purpose as it is in fractures.

It is probable that numerous other varieties of reflex spasm may be equally benefited by the remedy, so that investigations ought to be made in this direction.—*Jour. Am. Med. Assn.*, Oct. 19, 1889.

Money (A.) on Naphthalin.—I should like briefly to draw attention to the great temporary value of this antiseptic in cases of infantile diarrhœa and fetid urine. Rickets—by far the greatest creator of infantile diseases, the neurosis maker, the slime producer on respiratory, colonic, and vesical mucous membrane, and the bone deformer—is the chief parent of stinking stools and foul urine. Naphthalin in cachets, containing two grains for each year of the age of the infant, and given twice or three times a day, will alleviate the path of recovery whilst the dietetic

errors are being rectified. Naphthalin will not restore health to any mucous membrane flabby from rickets, but it will tend to do so, assisting in the process of recovery. A return from a rachitic constitution to a healthy one can never be brought about unless an attempt be made to increase vitality, whilst the metabolism is brought back to healthy modes of working by, in one word, a diabetic diet. The treatment of rickets, for one week at least, is the treatment of diabetes. A meat diet even without milk, persevered in for a few days, has caused slimy, worm-infested motions, to disappear, bronchitis to subside, and nocturnal restlessness to be replaced by calm, refreshing sleep.—*Lancet*, Oct. 5, 1889.

Cocaine Epilepsy.—Dr. C. Heimann relates the case of a man thirty-seven years of age, who had been in the habit of taking morphia. His druggist advised him to break the habit off by taking cocaine. He commenced by reducing the morphia to two grammes daily with eight grammes of cocaine. Six months after commencing this quantity his mind became affected, and three months later he was seized with a convulsive fit, which was repeated for several days. After recovery in hospital he was dismissed, and two months later he had a subcutaneous injection of cocaine, which again threw him into fits. After being dismissed from hospital a second time he took another large dose of cocaine, and immediately was seized with similar convulsions, and expired. Dr. Heimann considered this a case of cumulative cocaine poisoning.—*Med. Press*, Oct. 2, 1889.

Peters (L. G.) on Remarkable Effect of Quinine.—A woman, between sixty-five and seventy years of age, presents the following peculiar idiosyncrasy to quinine: Whenever she takes a grain of the drug it produces elevation of temperature (104° to 105° F. an hour after the dose), acceleration of pulse and breathing, rigors, slight delirium, nervous disturbance, thirst, dry parched tongue, and hot dry skin, with general malaise and every appearance of ill-defined fever. These symptoms pass off in from twelve to twenty-four hours, leaving the patient quite well. Similar symptoms have occurred three or four times in the same patient at intervals of some months, and in each instance within an hour or so after the dose of quinine.—*Lancet*, Oct. 5, 1889.

The Danger of Antipyrin.—A woman had taken thirty grains of the drug, in three equal doses, six hours apart, for the relief of a facial neuralgia, as she had occasionally done before without any untoward effect. I found the patient half an hour after the third dose was exhibited (which, by the way, was taken at the soda-water counter in a druggist's), in a condition approaching coma. The train of symptoms that occurred in the ensuing hour seemed all out of proportion to the amount of the drug administered: temperature, 103° F.; vertigo, chill, marked convulsion, nausea and vomiting, and decided impairment of respiratory function. On cessation of these phenomena the patient complained of her eyes feeling like live coals burning in their sockets. The heart's action during this time was in no way disturbed. Ought not the sale of this drug to be prohibited, except by prescription?—Anonymous letter to *Med. Record*, Oct. 19, 1889.

Bashore (H. B.) on Antifebrin in the Treatment of Headaches.—In headaches of the nervous type, in facial and supra-orbital neuralgias—not very severe,—I prescribe five grains every half hour, and in severe cases I give ten grains, to be followed by a similar dose in three quarters of an hour, if necessary; to be most effectual, the dose must be graduated according to the severity of the case and the peculiarities of the individual, and when this is accomplished the administration of the drug becomes very safe and its effects exceedingly reliable. Of five hundred or more cases of these affections which I have treated, I have given relief to all but a few, and in most cases the entire disappearance of pain followed the administration of the remedy. But it is in sick headaches that antifebrin seems to me to be the best of all remedies, not even excepting antipyrin, which I have used with excellent success; antipyrin will do well enough in the prodromal stage, but in the later stages may cause gastric disturbances and provoke that distressing symptom rather than allay it; in simple migraine, antifebrin is, I think, the remedy indicated, and if given in the beginning will almost certainly abort an attack. I have treated fifty cases at least of pure migraine, and I know of no failure to ameliorate the symptoms when the drug was properly administered, and here, too, the dosage is important; in the prodromal

stage of an ordinary attack, five grains every half hour was generally sufficient—if the case was further advanced, large doses at longer intervals are better, such as ten or fifteen grains every hour for two or three doses. If there is much gastric disturbance, the dose should be placed directly upon the tongue and very little liquid used in taking it; but it must be remembered that antifebrin will not so much cure an attack as abort it, hence the necessity for the early administration of the drug. I may add that I have lately used phenacetin as an analgesic, but found it in no way superior to antifebrin.

In regard to acetanilid-poisoning, I have only noted it once in all my cases, and in that instance a much larger dose than prescribed was taken. From my year's work, then, and its results I conclude that antifebrin is

1. A most effectual analgesic for headache.

2. The remedy, par excellence, for sick headache.

3. And that, when used with the precautions necessary in the use of all drugs, it is absolutely without danger.—*Med. Record*, Oct. 19, 1889.

MEDICINE AND PATHOLOGY.

DeWitt (W. H.) on Sub-Normal Temperature during Second Week of Typhoid Fever.—There was nothing peculiar in the history of this case during the first week. There was the gradual rise of temperature usually observed in these cases. I think the maximum reached was about 103.8°. During the first twelve days I prescribed four grains of antifebrin every five hours without producing the least disturbance; other than reducing the temperature at times almost to normal, this reduction not being accompanied at any time with chilliness or other indications of collapse. As I remember, at about this time I reduced the dose of antifebrin one half; that is, I directed the mother to divide each of the four-grain powders into two equal parts, to be given as before—every five hours. The evening of the second day after decreasing the amount of medicine, and about one hour and a half after administering the powder, he began to complain of chilliness, and broke out in a profuse cold perspiration; the pulse dropped down from 100 to 60 beats per minute, and became very irregular; the temperature at the same time fell to 96.8°. The father, being a physician and prominent specialist in the city, on entering the room recognized the change in the patient's condition and at once began the liberal administration of stimulants, which in a short time brought about the desired reaction. The father was disposed to attribute the depression to the antifebrin. I could not think so, from the fact that he had taken for more than one week very much larger doses without the least disturbance. However, to test the matter, the dose was reduced to one grain; still, at about the same hour each day, the same symptoms presented themselves. Finally, the antifebrin was dropped, to be still followed by the same peculiar train of symptoms. The sub-normal temperature, reduction of pulse-rate, and, indeed, all the symptoms observed in a state of extreme depression, developed each day for at least seven days.

There can, I am quite sure, be no question as to the character or nature of the disease. It was typhoid, with perhaps a malarial complication (typho-malarial). The stools were characteristic, and other abdominal symptoms were unmistakable. The duration of fever was about twenty-three days.—*Cincin. Lancet-Clinic*, Oct. 12, 1889.

Cancerous Affections of the Various Organs in Ireland.—Of the 2,003 recorded fatal cases of cancer in Ireland, the report just issued for 1888 shows that in only 67, or 3.3 per cent., was the part or organ affected by the disease not specified. There are, however, one or two facts brought out by the Irish statistics for 1887 and 1888 which deserve notice. In these two years the part or organ affected was recorded concerning 3,597 of the 4,070 fatal cases of cancer—1,578 of males and 2,019 of females. If we exclude from the female cases 460 cases affecting the breast and 325 affecting the uterus, the numbers affecting all other parts or organs in the two years are found to be 1,578 fatal cases of males and 1,228 of females. Of these numbers by far the largest proportion resulted from disease affecting the digestive organs, the pyloris, stomach, liver, intestines, and rectum; the cases so classed in the Irish returns for 1887 and 1888 were

846 of males and 823 of females. The cases attributed to the hand, leg, foot, and to other specified parts not separately classified were 214 of males and 167 of females. There remain to mention the cases affecting the head, face, eye, jaw, tongue, lips, neck, and throat; these numbered 518 of males and 238 of females. Thus while the relative numbers of cases affecting the internal digestive organs were 103 of males to 100 of females, those that we may call the external cases, probably due in great measure to injury from violence, affecting the hand, leg, foot, etc., were relatively 128 of males to 100 of females; and the cases affecting the head, face, eye, jaw, tongue, lips, neck, and throat showed the proportion of 218 of males to 100 of females. If we exclude the cases affecting the head, face, and eye, which may be referred in considerable proportion to injuries, and show less irregularity in the two sexes, we find that the proportion of cases affecting the jaw, tongue, lips, neck, and throat is 333 of males to 100 of females. Should a larger number of observations confirm the conclusion, drawn from these figures for 1887 and 1888, that while the sex proportion of fatal cancer affecting the digestive organs is nearly equal, the proportion in cases affecting the jaw, tongue, lips, and throat is 333 among males to 100 among females, it would be strange indeed if it were impossible to discover the true explanation of this remarkable difference. Some deleterious influence specially affecting these parts of the human economy more severely in the male than in the female sex would have to be sought. Without attempting to foreshadow the result of the quest of this deleterious influence in the eventuality alluded to above, it would, for instance, be absolutely necessary to investigate in the most thoroughly scientific manner the effect of tobacco-smoking upon the jaw, tongue, lips, and throat, which parts, judged by the figures at present at our command, appear to be more than three times as liable to cancerous disease in the male as in the female.—*Lancet*, Oct. 5, 1889.

Treves (W. K.) on the Diagnosis and Treatment of Scrofulous Glands.—I cannot help thinking that excision of scrofulous glands is an operation which rests on sound surgical principles. We have a diseased, an irreparably diseased, condition in organs which the body can well spare—a condition which tends constantly to cause infection by continuity of adjoining glands, and even by means of the blood, to develop tuberculous disease in distant parts. Why should this diseased product be allowed to remain to work its own sweet will unmolested and undisturbed? Tuberculous disease is removed from all other accessible parts or organs; why should glands be privileged? I submit there is every reason why they should be removed, and removed thoroughly. Take the case of a family of scrofulous tendencies. One member only may actually develop the disease, say, in the form of scrofulous glands; if this child's diseased glands are thoroughly removed, if all sources of irritation are removed and the child's health established by being sent to the seaside, that child is put back in the position of his brothers and sisters who have never had the disease. He is not more likely to have a return of the scrofulous glands than his brothers and sisters are to develop them—in fact, he is cured. The only valid argument that could be used against the excision of scrofulous glands is the possibility of undue risk. Scrofulous glands are situated usually in the midst of important vessels and structures, and their removal might be considered dangerous. I can only state that I have excised scrofulous glands for many years, and that I have never lost a case. I attribute this success partly to good-fortune, but mainly to the fact that I never incur, by premature closing of the wound, the slightest risk of retention of discharges or bagging. I have operated on many cases of great enlargement. I have removed more than a pound's weight in glands from one patient, and more than one hundred in number from another. I have excised glands in a case where the mass was sufficiently large to threaten suffocation. My colleagues are doing the same, and we can prove, by a great number of cases, that the operation is not attended with undue risk, and that the results are good.—*Lancet*, Oct. 5, 1889.

Robison (J. A.) on a Case of Phthisis Pulmonalis, with Uncontrollable Nasal Hemorrhages; Death from Exhaustion.—March 29, 1889, I was summoned to attend an engraver, aged ten. He had had pulmonary tuberculosis for three months. On examination, found a large cavity in the left infra-clavicular region. Was a tall, thin

boy, who had spent the greater portion of his life in-doors. No hereditary tendency to phthisis or hæmophilia in family, so far as could be learned. He had had no pulmonary hemorrhages.

Under treatment he improved until April 17th, when he was attacked by a severe nasal hemorrhage. The anterior and posterior nares were plugged and hemorrhage controlled for two days. An interval of one week passed, when the hemorrhage recurred. Same treatment and result. Ergot and the customary astringents did no good. April 27th to 29th, no hemorrhage. Then hemorrhage for two days; patient losing appetite, strength, and flesh, but expressed hopes of recovery and remained up all of each day. No hemorrhage until May 8th, when the most severe of all commenced, and lasted for three days. Patient almost completely exsanguinated. From this time until June 2d, there were slight daily hemorrhages. At no time had there been evidences of a pulmonary hemorrhage. Cavity in lung constantly increased in size.

June 2d an alarming hemorrhage set in and continued until June 7th, when the patient died from exhaustion, literally drowned in his own blood. He was so exhausted that he could not endure being handled, and his breath became so short that he would tear the plugs from his nose, and if restrained would become perfectly frantic. Seldom has it been my lot to witness a more harassing death scene. Death by pulmonary hemorrhage would have been preferable.—*N. Am. Practitioner*, Oct., 1889.

Tilley (R.) on Diabetes in Husband and Wife.[1]—I observed this phenomenon about five years ago. The husband was sent to me for examinination because he had been refused re-admission to a life insurance company, whose payments he had allowed to be in arrears. As I had to report the existence of sugar in the urine, the wife came to talk about the question and requested me to examine her urine also.

To my great astonishment I found hers also saccharine. I took precaution to have the husband pass his water in the office. For the sample from the wife I was dependent upon her veracity and care. The husband seemed to be the first affected.—*Weekly Med. Rev.*, September 28, 1889.

Bryan (L. A.) on Congenital Absence of the Uterus and its Appendages.—A mulatto woman applied for relief from an obstruction of the vagina which prevented perfect coition.

This subject is rather above medium size, well developed, twenty-five years old, has been married two years, has never menstruated, but suffers at each recurring period with severe pain in the head and feels a heavy sensation and some congestion of the eyes. When about seventeen years old, she was employed as a nurse by a lady of my acquaintance, who tells me that she had to relieve her from the care of the child for one or two days at each period on account of her severe suffering. She complained of no abdominal or other pains except those of the head.

She says that she has sexual desires and enjoys sexual intercourse, at the conclusion of which there is a sense or feeling as if something were in the vagina which she has the desire but not the ability to discharge.

The external organs were of normal condition and well developed. The index finger being passed into the vagina, found it in normal condition in all respects for about two thirds of its length from the vulva at this point; it was perfectly closed by a membrane of the same character and equally dense and resistant as that of the walls of the vagina. With the index finger in the rectum and a sound passed into the bladder, the vagina could readily be traced to its terminal point, which was abrupt, and beyond which no tissue of any character could be detected between the finger and the sound except the walls of the bladder and vagina; as far as we could explore there was no trace of a womb discovered. As this settled the question of an operation in regard to opening the vagina, we did not proceed to the painful operation of dilating the sphincter ani and introducing the hand into the rectum to search for a womb, for it was unmistakably demonstrated that if such an organ was anywhere located it had no connection with the vagina.—*Va. Med. Mo.*, October, 1889.

Althaus on Epilepsy after Vaccination.—On May 23d, a young man was admitted to a London hospital as an out-patient, in whom vaccination appears to have acted as the exciting cause of epilepsy. Dr. Althaus states that he has seen a number of cases, in very young children, in which the first occurrence of epileptic convulsions was attributed by the parents to vaccination, but that in all those cases

[1] See MEDICAL ANALECTIC, 1889, p. 468.

there appeared to be reasonable doubts. In the present case, however, it is perfectly clear that the blood-poisoning caused by re-vaccination was, indeed, the exciting cause of the seizures.

A letter-carrier, aged 19, a sturdy-looking lad, comes from a healthy family, and is one of ten living children, none of whom have shown the slightest trace of a neurotic tendency. As a boy he had measles, but no other ailment. He had been vaccinated as a baby, but, in accordance with the regulations of the post-office, he had to be re-vaccinated when, in June last year, he applied for a situation as postman. At that time he was perfectly well and strong, and his habits had always been steady. The vaccine took very well, but the lad soon afterwards began to feel ill, and swellings appeared in almost all the joints of the body. He was, however, in bed only for a day, which excludes the idea of rheumatic fever. He soon got up again and began his duties, and had his first epileptic fit about a month after he had been inoculated. Since then he has had fits about once a month, and they occur both in the daytime and at night. He has fallen down unconscious in the street on several occasions, while delivering letters, and has been on the sick-list four times during the last eleven months for a month or three weeks at a time. On the last occasion when he was ill he had fourteen fits in a single night. The symptoms of the seizure are well marked. He suddenly turns his head to the side, becomes unconscious and rigid, gets black in the face, bites his tongue, foams at the mouth, and is convulsed for three or four minutes; after which he recovers himself. He does not pass the excreta during the fit. If taken in the street, he has a very short aura, and then falls down. In the intervals between the fits he complains of headache, giddiness, and loss of memory, but there is no sign of organic brain-lesion.

Of the acute infectious disorders, it is chiefly scarlatina which appears to act as an exciting cause of epilepsy in children; after this come measles and typhoid fever; but vaccination has not hitherto been credited with producing this complaint. The present case is all the more interesting on account of the age of the patient, at which epilepsy does not commonly originate, and of the perfectly clean bill of health presented by his family and by himself previous to the vaccination. The blood-poisoning, which unquestionably originated in this young man from the inoculation, may have resulted from some slight admixture of blood with the vaccine-matter, although there is no actual evidence that such was the case; but, looked upon in this light, it would show once more the supreme importance of the most scrupulous care on the part of vaccinators with regard to this momentous point.—*Br. Med. Jour.*, Sept. 28, 1889.

Dangers of Celluloid Artificial Eyes.—Dr. Meurer, of the Lyons Ophthalmic Clinic, has published a paper warning medical men against the practice of ordering their patients who may require artificial eyes to get those made of celluloid. Such eyes are cheap, it is true, and have a good appearance. At first, too, they seem to suit very well, but after three or four months they appear to undergo some chemical change and set up a serious amount of irritation. He has repeatedly seen this inflammation disappear on the removal of the celluloid eye by means of simple antiseptic treatment; reappearing, however, as soon as the old eye was put in again, but remaining absent if a glass eye was substituted.—*Lancet*, Oct. 5, 1889.

Dana (C. L.) on the Pathological Anatomy of Chorea.—A male of 18 had had choreic movements twelve years. Later developed epileptic attacks of an hysteroid nature, and finally died of pneumonia. On autopsy there were found:

In the brain, chronic leptomeningitis, non-adhesive, and therefore not severe. Diffuse and varicose dilatation of the small arteries, especially of the deeper subcortical matter and capsule. Degenerative changes in the arterial walls; no arteritis. Circumvascular lymph spaces greatly dilated. Cortical cells in most regions normal. The severest changes—vascular, interstitial, and degenerative—were in the lower surface of the temporal lobes, in the internal capsule and adjacent parts of the corpus striatum, especially the lenticular nucleus, and optic thalamus, the antero-internal part. Varicose nerve fibres. Cell degeneration in some of the cranial nerve nuclei. Slight connective-tissue increase in the pyramidal tracts. In the spinal cord, slight leptomeningitis; congestion of the cord, especially in the lateral columns. Double central canal.—*N. Y. Med. Jour.*, Oct. 19, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

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OCCASIONAL REPORT ON DISEASES OF WOMEN.

BY JOHN S. HAWLEY, M.D.

Holmes (B.) on the Bacterial Origin of Puerperal Eclampsia.—Adopting the hypothesis that the phenomena of puerperal eclampsia are due to the toxic action of a ptomaïne, the author thus details the probable pathogenesis of the disease: The germs, not of necessity pathogenic in character, gain access to the circulation through the intestinal tract. The low state of vitality of the pregnant woman, and the low power of resistance to infection thus produced in the organs, leads to bacterial proliferation wherever capillary stasis exists, as in the kidney at a time when pressure of the gravid uterus, improper dress, or effects of "taking cold," etc., may have prepared a suitable place for germ development. A ptomaïne is thus produced, and the severity of the symptoms depends entirely upon the virulence which it may possess, and upon the extent of its production. Thus a very toxic ptomaïne may be produced from a small lesion, or extensive changes in the kidney may be accompanied by the production of so non-virulent a poison that this may be eliminated until a complete suppression of urine is caused by the renal changes.—*Am. Jour. Obstet.*, Aug., 1889.

Newman (W.) on Inversion of the Uterus.—The case cited was that of a woman, aged 23, who had been delivered of her first child sixteen months before by a midwife. She had had a tedious convalescence, and had suffered from slight but continuous bleeding since her confinement. The uterus was found to be inverted, the extruded portion bleeding at the slightest touch. Aveling's repositor was employed, and, after several failures, caused by slipping of the disc, the reduction was accomplished after about thirty-six hours' pressure (3 to 4 lbs.). Failure of the first attempts were due to imperfect fixation of the instrument, which was finally secured by elastic bands to rings attached to a belt of soap plaster applied at a point just below the iliac crests.—*Am. Jour. Obstet.*, Sept., 1889.

Allen (Thomas H.) on "Traumatic Cellulitis."—The author names thus a condition of the broad ligaments found in cases of laceration of the cervix with cicatricial deposit in the angles of the tear, not diffuse in extent or amenable to ordinary treatment. He maintains that the induration of the tissues, the pain, etc., are due to the irritation of the cicatrix—practically a foreign body,—the removal of which will result in disappearance of the abnormal condition. Early operation is therefore indicated in such cases—those of so-called "chronic cellulitis" accompanying cervical lacerations,—rather than tedious treatment for the removal of the induration on the broad ligament. He likens the cicatricial plug to a foreign body in the subcutaneous tissues of the arm, causing a chronic, non-suppurative, intermitting cellulitis, which can only be relieved by excision of the foreign body. The cicatrix in the angle

of the laceration prevents the completion of the "sphincteric arc of the circle with tissue histologically identical," and its removal gives a new impulse to nutritive processes. When reasonable efforts to remove the tenderness and thickening have failed, operation should not be longer delayed.—*Gaillard's Med. Jour.*, Sept., 1889.

[The author's theory of the ætiology of this condition is hardly in accord with the prevailing ideas as to pelvic inflammation in its relation to cervical injuries, and he is very liable to encounter the *anathema maranatha* of the pathologists. Certainly the inflammatory process antedates any possible formation of cicatricial tissue; and, though such deposit may interfere with the resolution of old inflammatory masses or thickenings of the broad ligament, it can scarcely be said to be the cause of the original process. We venture to predict that sooner or later a case of "traumatic cellulitis" will be encountered by the author which will tend to make him review both his pathology and treatment thereafter, at least in so far as operation while tenderness and swelling are present in the broad ligament is concerned. Even granting the author's hypothesis to be correct, the main difficulty in practice will be in the discrimination between septic and "traumatic" indurations as existing in a given case,—a matter of no common importance or diagnostic simplicity. Even if the affected tissues be the seat of an aseptic inflammation, they constitute a *locus minoris resistentiæ* to accidental infection at the time of operation and to consequent suppurative action.—J. S. H.]

The Curette and Paralysis of the Uterus.—Curetting the uterine cavity is an operation not unpopular with many gynæcologists, and therefore frequently performed. It is not without danger, and requires several precautions; above all, strict precautions against sepsis. Operators have occasionally noted during the scraping process that the curette seems suddenly to go through into a space, as though it had perforated the uterine wall. Doléris has described this phenomenon, which he has found to arise from total paralysis of the uterus, due to the "minor" operation in question. Dr. Geijl, of Utrecht, confirms this theory, having observed the phenomenon in five cases. He also noted complete paralysis of the vesical walls after removal of two tumors from the bladder, and injection of boracic acid. In the case of the uterus, the curette can be passed back till it strikes against the posterior wall of the uterus, and, on introduction of the finger, the paralyzed organ feels not like a flaccid bag, but rather like a distended sac. Fluids and air injected into the uterine cavity under these circumstances apparently resisted the pressure of the abdominal muscles. The question, discussed in the *Archiv für Gynäkologie*, vol. xxxi., part 3, is of high importance, and demands further investigation.—Editorial, *Brit. Med. Jour.*, Aug. 3, 1889.

Tait on Uterine Myoma.—The author, taking as a text a recent paper by Dr. Keith strongly upholding the treatment of these tumors by galvanism, presents the claims of salpingo-oöphorectomy as being more certain, scientific, and less tedious a mode of treatment, with the further advantage of an insignificant percentage of mortality. His own death-rate in 262 consecutive operations, was 1.23 per cent. and he complains of the silence on the question of mortality which has been observed by the advocates of the electrical treatment. Several cases are cited as operated upon successfully by himself after a long course of electrical treatment had been administered by others with either no effect or actual aggravation of the trouble. Electrical treatment for myoma is costly, not without danger, and uncertain both as to immediate results and permanency of the relief when such is afforded. More specific accounts of the results of this treatment must be given before it can be considered a rival to surgical methods. The author is opposed to abdominal hysterectomy except as an unavoidable operation, regarding as a prolific cause of its bad results the difficulty of treating the pedicle intra-peritoneally with any degree of certainty against secondary hemorrhage.—*Brit. Med. Jour.*, Aug. 10, 1889.

Logan (J. R.) on Cellular Atresia of the Nymphæ.—The case observed was that of a girl æt. five years and four months. Examination showed that when the labia majora were separated the integument covering their internal surfaces was continuous from one to the other, forming a complete covering to the vaginal orifice, and presenting an appearance as though the perinæum, as in the male, extended forward to the urethra. A small aperture was found just behind the meatus, through

which a probe could be passed into the vagina. The obstructing tissue was divided and the normal condition of the parts thus restored. The same condition had existed at birth in the case of the child's sister and of that of her maternal aunt.—*Canadian Practitioner*, Aug. 1, 1889.

Patterson (E. L.) a Glass-Ball Pessary Found in the Uterine Cavity.—The patient, æt. sixty-five, had, sixteen years previous, been treated for uterine trouble by the insertion into the vagina of a glass ball eight inches in circumference. She had then been sent home by her physician and had had no further treatment. In spite of the great pain and discomfort which were caused by the instrument, she had yielded to the advice of her friends, and had allowed it to remain. She had suffered from constipation and incontinence of urine since the ball had been inserted. Examination revealed the presence of the ball *within the uterine cavity*, the external os being dilated to about the size of a silver dollar. It was removed, after dividing the cervix, with much difficulty, and the patient rapidly recovered. How did the ball gain entrance to the uterine cavity?—*Med. Age*, Aug. 10, 1889.

Malins (E.) on Varicose Veins of the Broad Ligaments.—The broad ligaments chiefly consist of a network of large veins, freely anastomosing and poorly supplied with valves, and subjected to the presence of muscular fibres, which in contracting obstruct the free passage of blood through them. From any cause of disturbance of the pelvic circulation when long-existent—such as subinvolution or displacements of the uterus, excessive sexual indulgence, constipation, or general poor condition,—these veins become varicose and cause marked pelvic pain, increased when the patient is in the erect posture, as well as other sensations of "bearing down," leucorrhœa, etc.

The broad ligaments when touched in the rectal examination seem to be swollen and tender, but not as though the seat of inflammatory exudation. The cervix is congested and the vagina bluish in color. The treatment recommended includes local blood-letting, support of the organ by tampon and, when possible, by pessaries, improvement of the general health, and, as a last resort, excision of the veins by laparotomy.—*Am. Jr. Med. Sci.*, Oct., 1889.

[The author has evidently not read the article by Dr. A. P. Dudley on "Varicocele in the Female," published in the N. Y. *Medical Journal* more than a year since, as he makes no mention of Dr. Dudley's operations for the removal of the varix by laparotomy, and which were the first of their kind on record—that is, the first done to remove the veins and nothing else, the condition being diagnosticated before operation.—J. S. H.]

Baldy (J. M.) on the Early Diagnosis of Extra-Uterine Pregnancy.—The author's experience and studies have led him to take the following stand in regard to this subject, cases in his own practice being cited in support of each of his propositions.

1. In a certain proportion of cases of extra-uterine pregnancy, in the early stages, the diagnosis is easy and unmistakable.

2. In a certain (quite large) proportion of cases sufficient symptoms are present to more than warrant a diagnosis of extra-uterine pregnancy, such a pregnancy not being present.

3. In a certain other proportion of cases the symptoms, until rupture has occurred, are entirely wanting, or of such a dubious character as to in nowise warrant such a diagnosis.—*Med. Record*, Sept. 21, 1889.

Reed (C. A. S.) on the Treatment of Rupture of the Uterus.—The author makes an earnest plea for the immediate operative treatment of all cases in which the rent is considerable and the child cannot be delivered without increased risk to the mother. His conclusions are:

1. In cases of rupture of the uterus when the head presents, a cautious attempt should be made to deliver by the forceps. On account of the danger of increasing the rupture, turning is in all instances contra-indicated.

2. If the rupture be incomplete the uterus should be washed out with antiseptics.

3. Complete rupture always requires abdominal section.—*Cinn. Lancet-Clinic*, Sept. 28, 1889.

SURGERY.

Mayne (N.) on Remarkable Survival after Multiple Pistol-Shot Wounds.—On the evening of October 13, 1881, a rural postman, aged twenty-one, was seized by a would-be assassin, who fired several shots at him from a re-

volver, and having expended his own ammunition, called to a companion to "have at him now"; this man then continued the attack, and fired into their victim. *One of the bullets entered the brain, where it still remains, and causes little if any inconvenience*, although for nearly two years he could not bend his head or lean forward without giving rise to great pain and unpleasant symptoms. On making my examination I found a bullet wound on the left side of the head, about half an inch posterior to his ear, and immediately beneath the parietal eminence. Through this wound the brain substance exuded, and a small probe passed directly inwards for a distance of about two inches by merely letting it drop into the wound. On examining with the tip of little finger, no spicula could be found. Another bullet entered the left temple just above the zygomatic arch, about an inch and a quarter from the edge of the orbit; it took an inward and downward direction; its course, however, could not be traced. Another hit the angle of the jaw, took an upward direction, and was held between two molar teeth. One entered the left side of the chest on a line with the nipple, an inch and a half posterior to it, passed through the chest, and was extracted from the right axilla. One glanced off the great trochanter, and became lodged in the lumbar muscles. Two passed through the forearm about the middle. One entered the forearm about two inches from the wrist, took an upward course, and was extracted near the elbow-joint. One passed through the hand between the thumb and index finger. The skin on the left forearm and wrist was destroyed, the clothing having been set on fire by the powder. On the right hand the metacarpo-phalangeal joint was destroyed by the charge from a pistol loaded with shot, several grains of which and some of the paper used for "wad" were extracted from the palm of the hand.

The man was almost pulseless, and, the case seeming hopeless, it was decided by Dr. Allen and myself not to interfere, except symptoms demanded it, further than to cleanse and dress the wounds, carbolic lotion being used. He was given brandy and new milk or beef-tea every half hour. Coughing was severe for some days, and there was considerable hemorrhage from the lungs. He had also a sharp attack of double pneumonia. He was kept perfectly quiet and cool, morphia being given in minute doses hypodermically to relieve the cough, which caused terrible pain in his head. On the fifth day after being wounded he had considerable delirium, and could hardly be restrained, as he was "afraid of being taken to an asylum" at one time, while at another he thought his assailants were again attacking him.

This case, besides being interesting, I consider very important from the fact that, although being so fearfully wounded, the man did not lose consciousness till some time after he was brought to the police barracks, where he described one of his assailants and fully identified him. He was also able to describe a man who passed him soon after the attack; he also dragged himself to a house a few yards from the outrage, and begged to be admitted, and when refused, and feeling faint, hid the mail bags, and after "coming to" crawled to another house, prayed for admission, and to send for a priest. Being again refused, he "dropped down to die." He has no idea how long he lay there, but hearing a car pass he made an effort, and got to the road, where he was found in a fainting state by the police sent to look for him. The bullets removed were .450, or about the same size as those used for the British bull-dog revolver.—*Lancet*, Oct. 12, 1889.

The Reduction of Hernia during Coughing.—It is an undoubted fact that coughing will produce or bring down a hernia; it is therefore somewhat surprising to hear that coughing may be useful in the reduction of herniæ. M. Vandenabeele, however, has frequently found that herniæ which had resisted attempts at reduction by taxis alone yielded when the patient was directed to cough during the manual efforts to compress the sac. M. Vandenabeele's observations included both inguinal and femoral herniæ, and were not confined to either sex. He believes that during the act of coughing the hernial ring dilates somewhat, and that if well-directed taxis is employed just at the right moment most cases will yield.—*Lancet*, Oct. 5, 1889.

Millot-Carpentier on Necrosis of the Inner Third of the Spine of the Scapula, etc.—For many years a girl of fifteen had had what seemed repeated attacks of osteitis about the inner angle of the scapula, accompanied by swelling and multiple abscesses, followed finally by a fistula, which periodically discharged a

serous pus. There had been many years before a similar slight affection of the radius which had recovered spontaneously by elimination of the necrosed sequestrum. The fistula leading to the spine of the scapula was fifteen centimetres in length. Medicinal treatment was unavailing and the abundant intermittent suppuration and the attacks of pain at each period of inflammation finally drove the patient to an operation which was done under strict antiseptic precautions. The sequestrum which consisted of the inner third of the spine of the scapula was invaginated, but was successfully removed. The wound antiseptically dressed with iodoform gauze promptly healed.—*L' Union Méd.*, Sept. 17, 1889.

Laplace (E.) on Luxation of the Fourth Cervical Vertebra Resulting in Hemiplegia; Reduction and Cure.—On March 17, 1889, there was sent to me a patient, aged forty, a cotton-bale roller by occupation. While loading a ship with cotton bales, one accidentally fell upon our patient's neck, crushing him to the floor in the ship's hold. He remained unconscious for six hours, and on regaining consciousness, the attending physician noticed that the patient's head was drawn considerably towards the left side, that it was immovable, and that there was complete paralysis on the left side of the body. The patient remained in this condition about two weeks, when he gradually recovered sensation and motion in the paralyzed leg, but no improvement took place in the left arm. Electricity was applied for one month, but to no avail. There were tingling sensations throughout the limb, but scarcely any motion.

Two months after the accident, there being no further improvement, the patient was sent to me, and on examination the following condition was found: Anæsthesia all over the left arm and ranging up the shoulder to the middle of the neck of the left side. Slight power of flexion in the fingers. Cannot, however, grasp any thing. Evidences of slight atrophy in the arm and hand, the well-known glossy appearance being marked. There was considerable pain in the neck. This and the fact that the head was much drawn towards the left side, directed me to a more minute examination of the spinal column in the cervical region.

Beginning at the occipital protuberance and pressing with both thumbs, the underlying tissues appeared of a doughy consistence, and seemed congested. This appeared to extend as far down as the first dorsal vertebra. No fluctuation could be detected. There was one spot in the course of the cervical vertebræ which seemed much more sensitive, and this was over the fourth cervical vertebra. When pressing gently, but firmly, on either side of this point, a strange feeling of deep crepitation was detected. This was lost when looked for one inch above or below that spot.

We were naturally led to believe that there was a fracture of the spinous process of the fourth cervical vertebra, or perhaps of the transverse processes, and that the paralysis in the arm was maintained by the compression of one of the fragments against the spinal cord.

Being chloroformed, an incision four inches long was made in the middle line back of the neck, extending from the first to the sixth cervical vertebra, deep through the tissues of the spinal column, the parts were carefully retracted and the cervical vertebræ clearly laid to view, with all the proper aseptic conditions. It was then discovered that the spinous process of the fourth cervical vertebra was considerably to the right of that of the fifth cervical vertebra, and that whilst undergoing this luxation it had ruptured the posterior common ligaments and the capsular ligaments connecting these two vertebræ.

There was no mobility of the spinous process, and no fracture could be detected. The patient's head was bent forcibly; and by manipulation the luxated vertebra was restored to its normal position. The wound was disinfected with acid bichloride of mercury solution, and closed with catgut sutures. Union by first intention was obtained and the dressing was removed on the eighth day.

From the day after the operation the patient's arm seemed to gain more mobility. Sensation also improved. This gain was constant and increased steadily until three months after the operation, when there was scarcely any difference between the function of the left and right, or uninjured, arm. —*Times and Register*, Oct. 19, 1889.

Wylie (A.) on Extrusion of Gall-Stones by Digital Manipulation.—Mrs. S., aged forty-five, of a healthy family (says that her mother suffered from gall-stones for fifteen years), had always

good health till one night, about 12 o'clock, she was seized with a violent pain in the region of the gall-bladder, which lasted till nearly morning, felt sick and vomited; a day or two after this she noticed that her urine was a porter color and that her motions were pale. She suffered from a dull, aching pain in the epigastrium, with tenderness on pressure over the gall-bladder, and had deep jaundiced skin and eyes, with violent itching of the skin. In this state she remained over five months, gradually losing flesh and strength during that time. I tried almost every medicine that is recommended without the slightest result. She began to think that she would never get well, and asked me to allow her to go into a hospital, in order to have an operation performed. Before consenting, I tried digital manipulation with the best result. I commenced by giving a dose of tincture of belladonna, and, after a few hours, I dipped the fingers of my left hand deep into the abdomen below the liver, and with the right pressed gently on the fundus of the gall-bladder. By this means I could feel that I pressed out the contents, and within twenty-four hours I found a stone, about the size of a hazel-nut, in the motions. I continued the pressure over the liver and gall-bladder for ten or fifteen minutes at a time for the next four days. After this the jaundice disappeared, the urine lost its dark color, the motions regained their proper appearance, the patient got better rapidly, and in two months' time was quite well. Since then, I have had another patient suffering in the same way for over four months. I pursued the same treatment with complete success.—*Brit. Med. Jour.*, Oct. 12, 1889.

Little (J.) on Suicide Apparently by an Attempt to Cut Off the Head from Behind.[1]—I notice in *The Lancet* of June 22d, the record of a case, under the care of Mr. Hulke, of suicide apparently begun by an attempt to cut off the head from behind. The forensic interest attached to this case induces me to publish the details of an even more determined case which occurred in my practice on July 2, 1879.

A woman, aged thirty-six, had been discharged apparently cured about a week before from Garlands Asylum, where she had been an inmate about three months, with the symptoms of puerperal insanity. About 8 A.M., on July 2, 1879, the daughter of the patient came for me, saying that her mother had attempted to commit suicide, and on arriving at the house I met a ghastly spectacle. She had a knife in her hand, and on the back of her neck was a huge wound, which had apparently taken half her head off. It had gone through skin, muscles, ligaments, the very bone itself, and had opened into the spinal canal, but had not touched the cord. The head itself, having lost all its connections at the back, was bobbing about in a manner that would have been ludicrous had it not been so ghastly. The instrument was a blunt and rusty table knife, with which she had been peeling potatoes. On being questioned as to her object in committing suicide, her only reply was that she did not know. Such treatment as was possible was applied, but she died on the sixth day from septicæmia. No post-mortem was obtained.

The chief interest of the case lies in the fact of the wound having undoubtedly been committed by herself, and in the very determined manner in which she had set to work apparently to decapitate herself.—*Lancet*, Oct. 19, 1889.

Strong (C. P.) on the Surgical Treatment of Backward Displacements of the Uterus.—From the results of my own operating I have drawn for my guidance the following rules:

Be sure that the displacement is the cause of the symptoms. Never resort to operative measures without first exhausting all forms of non-surgical treatment in so far as they may be applicable to the case under consideration. An adhesive backward displacement of the uterus demands for its cure, first, separation of its adhesions; second, anterior fixation. Separation may be accomplished, first, by forcible divulsion without opening the abdomen; second, by laparotomy and subsequent divulsion or cutting. The advantages of the first method are that in suitable cases the patient is exposed to few dangers beyond a simple traumatic peritoneal inflammation. The advantages of the second are that it supplements the first; assuming greater risks it strives for greater successes; the adhesions being dealt with more openly, any accident that may arise is more easily remedied; it can be employed in cases to which the first is inapplicable. It super-

[1] See MEDICAL ANALECTIC, 1889, p. 345.

adds, however, the dangers of a laparotomy.

A backward displacement which is free originally or which has been *freed from its adhesions* may be secured forward. First, by shortening of the round ligaments, either by the Alexander-Adams or Wiley method; second, by fixation of the uterus to the peritoneum of the anterior abdominal wall, or to that of the anterior pelvic floor (Schücking's method).

Of the four operations, the only one not involving interference with the peritoneum is the Alexander-Adams. I believe that it should be selected, from my own experience of its successful results. I make an exception, that if for any *other* reason the abdomen has been opened, Wiley's operation may perhaps prove its equal.

These round-ligament operations leave the uterus in practically a normal position, without undue tension on tubes, intestines, or blood-vessels. There is no danger of fæcal fistulæ or incarceration of the intestines; no interference with subsequent pregnancies. Permanent successful results do not depend upon adhesions or suspensory stitches, and the uterus is left movable, not fixed.—*Boston Med. and Surg. Jour.*, Oct. 17, 1889.

Ryan (G. W.) on the Orthopedics of Infantile Paralysis. — The author reached the following conclusions:

1. That orthopedic treatment, in conjunction with local treatment of muscles, is useful in all children who have arrived at the walking age. It gives support and prevents deformity.

2. That it tends to preserve, in a measure, the proper balance between antagonistic groups of muscles by aiding the weakened group and restraining the normal ones.

3. That by this means the paralytic group are given the benefit of any movement of which they are capable, and in this way can they get exercise.

4. That it certainly can correct deformity.

5. That a heavy appliance, or one adjusted by lacing bands to the leg or thigh, does more harm than good.

6. That such measures are a necessity in the after-treatment of divided tendons and muscles.

7. That in most contractions it is better to divide than to stretch them.— *Med. Record*, Oct. 26, 1889.

THERAPEUTICS.

Richardson (A. J.) on Antipyrin.— In only four of ninety-six cases has any bad effect been attributed to the drug. In a pregnant woman suffering from left-sided hemicrania, twenty minutes after she had taken ten grains an itching "white raised rash" appeared, diagnosed by a chemist as due to mussel poisoning. She had, however, taken nothing to which I could attribute it save the antipyrin. A patient with tabes dorsalis, after taking twenty grains fainted away, and is said to have lain insensible on the floor. One patient vomited after a dose of twenty grains, and one after a dose of ten grains; both, however, took it during a paroxysm of migraine, so it is very probable that the drug was not wholly to blame. In only the two above-mentioned cases was a larger initial dose than ten grains employed; I shall not repeat it. Thirty-eight of the cases were typical migraine; in nearly all I ordered ten-grain doses, to be repeated in an hour if the pain did not abate. In thirty-two cases the improvement was definite, in two doubtful, and four were unbenefited. In the successful cases, as a rule, not only were the paroxysms relieved, but their frequency was diminished. In three, after a time, the power of the drug seemed to fail, but an increase of the dose to fifteen grains produced the initial good result. In some cases, although the paroxysms were always relieved, their frequency was in no way affected. In none was the frequency increased. In two of the cases peptonuria was constant; both were relieved as to the migraine. The condition of the urine was observed in intervals as well as in paroxysms. Of the four cases in which the drug failed, one had, I believe, mitral obstruction, through which the migraine might have been aggravated; one vomited the antipyrin, probably before any therapeutic effects could have been obtained; the other two cases were both definitely hemicranias, and I have sometimes been tempted to think that the more definitely the migraine conformed to this type the less good was to be expected from antipyrin. In sixteen cases of head pain, some of which I could not explain at all, and none of which were markedly typical, the drug relieved in eight. A very different proportion to that on migraine, showing that the administra-

tion of the drug in a purely symptomatic manner meets with no undeserved success.

To detail the cases in which it failed: 1—Headache in anæmia, with possible gastric ulcer. 2—Violent vertical headache, possibly syphilitic. 3—Headache, associated with astigmatism (unrelieved by glasses) and gastralgia; improved under arsenic. 4—Vertical headache in a phthisical patient. 5—Rheumatism of scalp. 6—Continuous headache "all her life." 7—Temporal headache, possibly middle-ear disease. 8—Temporal headache.

In three cases of anæmic headache in chlorotic patients, contrary to my expectation, the drug relieved. These were not cases of migraine in chlorotic girls, but were headaches which were worse in the morning, unaccompanied by sickness or visual phenomena, and which got better as the day wore on, or on lying down. In four cases of tabes dorsalis, with lightning pains, my administration of the drug met with the most favorable results. All now invariably keep it ready for immediate use. One of the patients suffered from the most distressing nocturnal rectal tenesmus; on this the drug, although tried repeatedly, had no effect, but his lightning pains, of the most severe description, were at once relieved. Four times I have ordered ten grains to be taken at the onset of an attack of asthma nervosa, in all without any relief of the spasm. In three cases of facial neuralgia (in none of the patients was there any dental caries), one was much relieved and two but slightly; and it is noteworthy that the most successful case had previously taken in vain croton-chloral hydrate and tinctura gelsemini, whereas one of the but partially successful cases was at once relieved by croton-chloral hydrate. Unfortunately, I know of no difference between the cases. In one case of brachialgia great relief was experienced after a vast variety of drugs had been futilely exhibited. One case of proxysmal sneezing and two of severe pain in the feet with no apparent cause were relieved.—*Lancet*, October 19, 1889.

Bourns (D. C. G.) on Unusual Effects of Antipyrin.—A neuralgic patient, who has taken twenty-grain doses of antipyrin quite often for two years, has got relief from the neuralgia, but has found that the drug produces a condition of the lips, tongue, and mouth which almost counterbalances the relief obtained from the neuralgia. About half an hour after the administration of the drug a slight itching of the lips and tongue is observed, accompanied by an increased flow of saliva. The lips assume a dark-purple color, with a sharply defined edge where the mucous membrane runs into the true skin, exactly like the painted lips of actors when closely seen. This is followed by considerable swelling of the tongue and small white patches on the surface of the labial, buccal, and sublingual mucous membrane, which extends to the fauces when the dose has to be repeated. At this period the pain and irritation are considerable, mastication is impossible, and even the swallowing of fluids causes no little difficulty. In the course of twenty-four hours small shallow ulcers take the place of the white patches, and subsequently heal readily enough. I may add that from first to last there is no constitutional disturbance.—*Br. Med. Jour.*, Oct. 12, 1889.

Raymond on Sulphonal.—M. Raymond has recently tested, at the St. Antoine Hospital, the value of sulphonal as a narcotic. Though far from being an ideal narcotic, it proved useful in many cases. It had scarcely any action on the respiratory system; on the circulatory system it had the same influence as sleep when this was natural; the temperature was slightly lowered. The secretion of urine was increased; that of the sweat glands diminished. The tongue and mouth were sometimes dry; occasionally, though rarely, the patient vomited. M. Raymond found that sulphonal was not an anæsthetic; it had sometimes a hyperæsthetic action. Small doses had no influence on muscular contractility; doses of six grammes were followed by ataxic movements of the limbs. Doses of one or two grammes were safe; women were more easily affected by sulphonal than men. Progressively increasing doses were unnecessary. After a certain time it could be discontinued; sulphonal was superior to morphine in this respect. It was especially useful in insomnia resulting from general debility, neurasthenia, and cerebral disturbance; where there was actual cerebral lesion, the action of sulphonal was more intense, and in such cases it had to be administered with great care. Sleeplessness from abuse of morphine was relieved by sulphonal; it was also useful in phthisical patients who were rendered sleepless by coughing. It was

inert when sleeplessness resulted from rheumatic pains, sciatica, cardiac troubles, also in Bright's disease and intense dyspnœa. Sleep produced by sulphonal was calm, lasted from six to eight hours, and came on about half an hour or one hour after administration. The disadvantages attending the use of sulphonal were fatigue, giddiness, and sometimes positive vertigo. —*Brit. Med. Jour.*, Oct. 12, 1889.

Prince (L. H.) on Salol in Typhoid Fever.—A woman of twenty-five, had always enjoyed most excellent health, with the exception that she was obliged to resort to the use of laxatives to keep her bowels in order. On February 24th last, the date of my first visit, she complained of having for several days felt tired and sleepy, with a disinclination for any kind of work, and "ached all over" most of the time. Her appetite was quite capricious, one day being as usual, the next entirely absent. There had also been more or less diarrhœa. For a few nights had been feverish and restless, and her husband stated that she had talked in her sleep. On the 22d had a few slight chills. At the time of visit, the night of February 24th, patient's temperature was 103°; pulse, 100. Tongue trembling, thickly coated with dirty, white fur, edges red. Abdomen tympanitic, and on pressure in right iliac fossa there was gurgling and marked tenderness. Fæces thin, dark-yellow, and of a very offensive odor. Urine scant and high-colored. A lime-water and milk diet was ordered, brandy occasionally, and perfect quiet in bed. Salol, in powders of six grains each, was given every three hours. In thirty-six hours the temperature had fallen to 97.5°; there was a rise to 99.5° on the third day; on the fourth day, 97°. It reached normal on the fifth day, and remained so morning and night the rest of the time.

The other symptoms rapidly lessened in severity. Towards the end of the first week the abdomen and lower part of chest were covered with rose spots, but these all disappeared in a few days. There was a considerable though not great loss in weight, and the patient lost a few handfuls of hair. At the commencement of the second week she begged for solid food and wished to get up. There was no delirium, and very little nervousness or loss of sleep. At the end of the second week the salol was discontinued and the patient allowed to get up and partake of solid food. In another fortnight she was in her usual good health.

Salol may be given in doses of from two to eight or even ten grains every three or four hours, according to age and severity of symptoms.—*Western Med. Reporter*, Oct., 1889.

Kloman (W. C.) on Poisoning by Illuminating Gas.—On September 4, 1889, I was called at 6:30 A.M. to see a colored girl, aged seventeen years, a domestic. She went to bed at about 10 P.M., and was found insensible in her bed at 5 A.M., or soon after. The room-door and window were both closed, and the atmosphere filled with the smell of escaping gas. The stop-cock was found partially turned off. Before my arrival she was moved to the adjoining bath-room, where the window was open. I found her lying upon the floor; her limbs were cold and relaxed; I could feel no pulse at the wrist; there was no sign of life except respiration, which was shallow and stertorous. The eyes were partly open, staring, and fixed; the conjunctivæ were intensely congested; the pupils moderately dilated and insensible to light; the eyes were also insensible to touch. She was in a profound coma. I at once dissolved a hypodermic tablet of nitroglycerine, one fiftieth of a grain, in my hypodermic syringe, and injected the solution into the upper arm. Her body was directed to be covered with blankets. In about two minutes I could feel pulsation at the wrist, and in five minutes her pulse was full and strong. *Pari passu*, the respiratory movement deepened, and her limbs began to grow warm. In about fifteen minutes, while yet unconscious, she showed signs of vomiting; I turned her on her side, and she vomited some mucus and partly digested food containing some pieces of tomato. Soon after this she became partly conscious, and, reaction being thoroughly established, I wrote a prescription for æther. sulph., ℥ ss.; elix. ammon. valer., ℥ jss., and directed that during my absence a teaspoonful diluted with water be administered every second hour. I returned to see her in about three hours, when, to my surprise, she walked into the parlor. She told me she was all right except for a slight headache. She also said that she had been constipated for several days, for which I ordered her a purgative. Beyond this she had no medication. Her

headache continued for two or three days, but did not interfere with the performance of her duties.—*N. Y. Med. Jour.*, Oct. 26, 1889.

Lactose as a Diuretic.—M. Germain Sée, at a recent meeting of the Paris Medical Academy, stated that lactose as a diuretic is preferable to milk. Many cardiac patients are unable to swallow large quantities of milk, whereas *tisane lactée*, tisane mixed with lactose, is easily tolerated. One hundred grammes of lactose administered daily acts more powerfully as a diuretic than four or five litres of milk. Lactose is a valuable diuretic agent in dropsy, a frequent complication of certain forms of heart disease; for these cases, M. Germain Sée considers lactose superior to strophanthus or digitaline.—*Br. Med. Jour.*, Oct. 5, 1889.

Oliver (T.) on Cocaine in Diabetes.—The points of interest in the case reported as the result of the administration of cocaine are—the total disappearance of a most obstinate constipation which refused to yield to the strongest purgatives; disappearance of a gait, not unlike that of ataxia; of delusions, and a sense of muscular fatigue; the return of a feeling of improved health and strength, with a grain in weight; a marked diminution in the amount of urine excreted; a very decided reduction in its specific gravity and a very noticeable fall in the daily elimination of sugar. Cocaine failed, however, to raise the temperature. The usual dose was ¼ gr. three times a day.—*Lancet*, Oct. 12, 1889.

Fell (G. E.) on Forced Respiration.[1]—In addition to the cases already published by the author, he now cites five more where forced respiration has been employed in opium poisoning:

In one, recovery followed after the ingestion of two ounces of laudanum. Much blood had been lost from a cut-throat in this case and ʒ viii. of a ¼ % salt solution was injected into the veins.

In a man of eighty ʒ i. tr. opii proved fatal, although forced respiration was kept up for twelve hours.

A baby of eighteen days died from the effects of gr. i. morphia. Treatment was not instituted until the poison had been retained for five hours.

In another case a large but unknown quantity of morphia proved fatal in spite of treatment. In the fifth case ʒ ii. tr. opii were taken, and forced respiration, kept up for eleven hours, saved the patient.—*Jr. Am. Med. Assn.*, Oct. 12, 1889.

[1] See MEDICAL ANALECTIC, 1887, p. 536; 1888, pp. 128, 624.

MEDICINE AND PATHOLOGY.

Rachford (B. K.) on Experimental Studies on the Etiology of Typhoid Fever.—It is not my belief that all the symptoms of typhoid fever are produced by ptomaines formed in the intestinal canal, since these poisonous bodies are undoubtedly produced in all parts of the body where the bacilli find a lodgment and multiply. It is also probable that certain symptoms may be due to a local irritating effect of the ptomaines on the part in which they are produced. While this is probably true, it is nevertheless a belief supported by much clinical evidence that the intestinal canal is the great manufactory and storehouse for these poisons, and that most of the constitutional symptoms throughout the disease are due to the absorption from this source.

In the following experiments I injected into a rabbit's stomach the whole culture containing the active bacilli as well as the products of their growth, because I feared that in attempting the destruction of the germs by heat or otherwise I might also destroy or change the character of their ptomaines. This course was decided upon because it was my belief that rabbits were not susceptible to typhoid fever, and for this reason I concluded that the introduction of the typhoid bacilli could have no appreciable effect on the symptoms, and that the result would therefore be either directly or indirectly due to the chemical products introduced with the culture. These experiments are, I think, of some interest in the direction anticipated, but their chief value lies in the fact that one of the rabbits died from typhoid fever, and not from poisoning by the ptomaines introduced into its stomach.

The bacilli used in these experiments were from the stock cultures of the bacteriological laboratory of the Medical College of Ohio, and were from two different sources.

One half the cultures used were descended from the culture received from Johns Hopkins University six months before. The other half were descendants from a culture made one year before by Dr. Otis Cameron from the spleen of a man who died from typhoid fever in the Cincinnati Hospital. The culture materials used were :

1. Peptonized milk.

2. Peptonized beef. This was made by mashing into a fine pulp the coagulate resulting from making beef tea, adding it to the tea and peptonizing the whole.

3. Peptonized brain, made in same manner as the beef.

4. Bouillon and beef peptonoids.

These materials were put in test-tubes, and sterilized in the ordinary way. Only tubes which more than three weeks' time had proved to be sterile were used. After inoculation these tubes were placed in a crate, wrapped in paper to exclude the light, and kept in a temperature of 94° to 98° F. My object was to furnish conditions as nearly resembling those found in the intestinal tract as possible.

The rabbits were inoculated as follows : From sixty to eighty minims of tincture of opium were injected into the peritoneal cavity. As soon as the rabbit became drowsy from the opium, four drachms of a 5 per cent. solution of bicarbonate of soda were injected through a stomach-tube into the rabbit's stomach, and in the same manner, directly afterward, the contents of a typhoid culture tube were thrown into the stomach. The rabbits were then placed in separate cages, and given plenty of cabbage and moist bread.

The purity of the culture used was tested in each instance, by inoculating potatoes, just prior to their use. In this manner it was learned that all the cultures used were pure typhoid.

The first four cases were treated exactly alike. Each one was inoculated with the same quantity of pure culture three and a half months old in bouillon to which beef peptonoids had been added. The clinical histories of these rabbits correspond very closely. All of them had a slight increase in temperature, 102° to 103° F., and were dull and stupid from the beginning. One lived three, one three and a half, one four, and one twelve days. In the rabbit that lived twelve days the stupor disappeared on the fifth day, and the temperature fell below normal on the eighth day, and remained so until death. In this case diarrhœa set in on the eighth day, and became profuse. The post-mortem examination in this case showed : Great emaciation ; no evidence of disease, except in small intestine, which was deeply injected. This injection was especially marked in the ileum, about Peyer's glands. Four small follicular ulcers were found in the ileum opposite the mesenteric attachment, while deeply injected blood-vessels radiated from these ulcers.

We may at least claim that these experiments indicate that typhoid bacilli, when grown in beef peptonoids, will produce ptomaines capable of producing fever and profound nervous symptoms.

In a series of four other cases it was noticed that there was no marked difference in the symptoms of those treated with a culture in peptonized brain and those treated with a culture in peptonized beef. All were quite stupid from the first day and all had subnormal temperatures on the third day, this being the first day upon which their temperatures were taken. Two of these rabbits lived seven and two nine days.

In comparing the clinical histories of groups 1 and 2, the following point is worthy of note : *i. e.*, that the beef and brain ptomaines are less virulent than the peptonoid ptomaines.

It must also be borne in mind that there may be a possible error in the above inference dependent on the fact that the cultures used in the two groups differed in age. Those used in group No. 1 were three and a half months old, while those used in group No. 2 were two months old. This may account for the difference in severity but probably does not account for the difference in character of the symptoms produced.

One of the last series of cases is so interesting that it will be reproduced in full.

No. 10.—Rabbit—Age twelve weeks. Inoculated March 24, 1889, with a pure culture two months old in peptonized milk. Germs descended from spleen culture. March 25th and 26th, temp. not taken ; apparently well. 27th, temp. 102° ; very active ; eats well. 28th, temp. 101.6° ; active ; out of box ; eats well. 29th, temp. 97.2° ; not active. 30th, temp. 99.4° ; active ; good appetite. 31st, temp. 95.4° ; not active. April 1st, temp. 99° ; active ; good appe-

tite. 2d, temp. 98.6°; diarrhœa; not active; eats well. 3d, temp. 96.4°; diarrhœa; eats well; dulness and stupidity apparently due to weakness. 4th, temp. 95°; very weak and stupid; diarrhœa. 5th, temp. 95°; cannot stand alone. 6th, died this morning. Post-mortem (present Drs. Chapin, Cameron, and Freeman, and laboratory class, twelve hours after death): Extreme emaciation. Lungs and liver showed no evidence of disease; spleen normal in size; kidneys enlarged and congested. The small intestine was carefully removed and thoroughly washed by allowing a stream of water to run through it; when distended with water and held before the gaslight points of pronounced hyperæmia were seen at intervals of a few inches throughout its length. These points were more numerous and better marked in the ileum than elsewhere, and marked the location of follicular ulcers and of Peyer's patches.

Sections of the gut showed that Peyer's glands throughout the ileum projected abnormally above the surface of the mucous membrane, and were much injected, one patch, about six inches from the cæcum, was slightly broken down in its centre, apparently a beginning ulceration. Some twelve or fifteen ulcers were found in the small intestine. They were chiefly located in the ileum. These ulcers were clearly defined, circular, deeply injected, about one sixth to one eighth of an inch in diameter, and situated opposite the mesenteric attachment.

From a plate culture made from the spleen there was obtained a culture of bacillus, which in drop culture and stained coverglass preparation was morphologically identical with the typhoid bacillus. This bacillus on potato gave a moist colorless growth, covering the whole surface of the potato.

Sections of kidney and spleen were stained and found to contain bacilli which corresponded in size and shape to the typhoid bacilli.

The rabbit (No. 10) did not show the slightest evidence of ptomaine poisoning. It remained apparently well for four days —during this time being quite active, eating well, and having a normal temperature. On the fifth day it showed evidence of sickness and from this time grew gradually weaker, dying on the tenth day of its sickness and fourteen days after inoculation. The symptoms were: subnormal temperature, gradual emaciation, diarrhœa, failing strength, and dulness. When this clinical history is taken in connection with the post-mortem lesions and biological examination it seems reasonable to conclude that this rabbit died from typhoid fever. The only way to avoid this conclusion is to argue an error in the technique.

In the study of the physiological action of typhoid ptomaines introduced with the cultures, it is quite evident that the early symptoms are all-important, since the symptoms which occurred after the third or fourth day could not have been due to the direct action of chemical poisons introduced with the culture. In the comparison, therefore, of group 3 with groups 1 and 2, it will be necessary to consider only the early symptoms.

The stupor, which is the most prominent symptom in groups 1 and 2, is entirely absent in group 3. The fever in group 1 was increased, in group 2 the temperature was subnormal, and in group 3 it was normal. In short, all the early symptoms which characterized the cases in groups 1 and 2 were absent in group 3. These facts would indicate that the typhoid bacillus when grown in milk, does not produce ptomaines capable of producing either fever or nervous symptoms, and that if the ptomaines thus formed are at all poisonous, they are much less so than those formed in beef peptonoids.

Now, in conclusion, let us note that there are three important propositions to which these histories bear witness:

1st. The bacillus typhosus of Koch and Eberth is the cause of typhoid fever.

2d. The physiological and poisonous properties of the ptomaines formed by this bacillus will depend in great part on the character of the food material in which it is growing.

3d. Milk is the best diet in typhoid fever, since the ptomaines produced in it do not cause either fever or nervous symptoms.—*Med. News*, October 26, 1889.

Medical Practice in South Africa.—A doctor writes, to the *Lancet*, Oct. 29, 1889, from the Orange Free State, as follows: 'My opponent is an unqualified practitioner who was formerly a sailor and deserted from his ship. Afterwards he became in turn a police constable and a butcher. He was attending a child who died yesterday. He is now making its coffin.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

With the active collaboration of

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OCCASIONAL REPORT ON NERVOUS AND MENTAL DISEASES.

BY FREDERICK PETERSON, M.D.

Gowers (W. R.) on the Elaborate Diagnoses of Neurologists.—A tendency is often to be observed in the present day to underrate diagnosis, or at least the elaborate diagnosis of which the diseases of the nervous system furnish so many examples. In the face of the urgent needs of suffering humanity, with its mute or uttered cry for the relief we cannot always give, our precise distinctions and elaborate processes may seem like an ingenious device for interesting us while the patient suffers. That such an impression is wholly wrong I need not say to those who hear me now; but the tendency is real; it is reflected beyond our own ranks; and I may give one warning—a warning to myself as well as to others,—that we should be always on our guard lest we do any thing, by word or manner, that may excite or foster the feeling to which I refer. Diagnosis must come before treatment, but this should make us careful lest we produce an impression that we regard the order of the two in time that also of their importance—an impression easily produced when, as often, the treatment is plain and its methods familiar, while the diagnosis is complex and its processes strange.—*Br. Med. Jour.*, Feb. 2, 1889.

Myrtle (A. S.) on False Neurasthenia. — Here we find symptoms in every respect similar to those of true neurasthenia, and it will take you all your time and patience, as well as tact, to detect the sham from the real. If you hark back a bit, you will find that as a child she showed temper; was wayward; as she grew, she became fitful, hysterical, and given to the sulks; craved for sympathy, and exhibited little or no sympathy for others. On questioning her, she describes her sufferings in forcible language. She can neither eat nor sleep; has not an atom of strength; suffers from the most dreadful pain, most fearful headaches, and frightful spasms; and should you suggest any portion of her body, from her head to her heels, as possibly exempt from pain, she often resents the insinuation, and declares *that* is the very part where she suffers most. Whilst she tells you all this in a sort of whine, her features don't show indications of any agony, and, if you watch her, you will find that she overacts her part. Utterly indifferent to the anxiety of parents and friends, or to the trouble and expense she causes, she seemingly finds gratification in watching the unwearied efforts of those around her in doing their best to comfort and help her. Whilst putting on an air of the most abject listlessness whilst you look at or speak to her, if you talk at her you will learn that she has both eyes and ears; if you assist her in any way she makes herself as helpless as she can—a dead weight. These creatures not only deceive every one around them, but in time they succeed in deceiving themselves. Were it not so, I cannot understand how

they continue playing such a sorry game for so long, and with so much strain and fixity of attention to the exclusion of every thing else as I have seen them do. If we push our inquiries a little further, we generally discover that there is some obliquity of the moral sense; an ungratified whim or disappointed affection at the bottom, and that whilst the patient will be abed for weeks, or on a couch, quite unable to do any thing, suddenly some evening she will announce her intention of going to a ball, where she will dance the whole evening; or she may take it into her head and mount her horse, and, should she meet with hounds, join in the chase, and, what is more, ride straight. — *Provincial Med. Jour.*, Feb. 1, 1889.

Jastrowitz on the Treatment of Insomnia.—At the meeting of the Society for Medicine of the 1st inst., Herr Jastrowitz gave an address on the subject. He first spoke of the employment of alcohol in its various forms of wine, beer, and spirits. Alcohol was given as a narcotic in acute diseases in cases in which it was desirable to use one that was not a cardiac depressant. Alcohol was first a cardiac whip, and then, when the stimulant action had passed off, a "somniferum." In chronic insomnia from cerebral disturbance it was a well-known prescription to make patients work hard or run fast, and then give them some strong beer. But even if alcohol was useful in furthering sleep, in melancholics the dread and nervous excitement were often made worse the following morning.

As regarded opium and morphia, it was a noteworthy fact that G. Mayer, of Aachen, considered them first as sedatives, and hypnotics only in large doses. A third property, that of a tonic, was very valuable. Persons who had become accustomed to take other hypnotics, after taking opium and morphia thought that the sleep following these was the most natural. These were indispensable sedatives in such diseases as cancer and tabes. It might be disputed that morphia was a tonic, but the experiences of sportsmen on themselves and their horses showed that after injection of morphia they were able to accomplish greater feats than without. The effect of morphia in stenocardia, angina pectoris, and feeling of dread from deficiency of tone in the medulla oblongata, were mentioned. In congestion of the chest great caution must be used with morphia as well as in diseases of the heart, as both paralyze the heart. These drugs must be used with great caution in chronic insomnia, for fear of setting up a dangerous and intractable morphia habit. Small doses only should be given to children in whooping-cough, and bromide of potassium substituted where it could be done. In senile insomnia opium acted better than morphia; was superior also in intestinal diseases and in certain forms of melancholia and mania. He had used it gladly in delirium tremens. Codein and narcein were the only other alkaloids from opium in use. Both caused less constipation, and were fairly good hypnotics. In Russia and France codein was much used in bronchitis, and Lauder Brunton recommended it in abdominal pains. Narcein was much used in France for children. Chloral hydrate had the advantage of being the most powerful of all hypnotics. It never failed. Danger from it naturally increased with the dose. A large dose of chloral produced a condition resembling chloroform narcosis, which lasted till natural sleep followed. It was contra-indicated in cases where the lungs showed great obstacles to respiration, and where the stage of excitation was very short, especially where there was no contraction of the pupils. He had in 1869 recommended a mixture of chloral and morphia; it had advantages, but it should never be given in large doses. Paraldehyd did not depress the heart. Large doses produced a condition resembling chronic alcoholism. It was not very dangerous. Patients quickly got accustomed to it, and the dose had to be increased. It was not suitable in bronchial irritations, but in affections accompanied by cutaneous itching it was very efficacious. It was not very useful in conditions of great excitement and dread, but in insomnia from "moral" causes it was. Hydrate of amyl had the fate to be quickly overtaken by sulphonal, but it was a good hypnotic in doses of 0.8 to 1 gramme.

Sulphonal was distinguished by its odorlessness and tastelessness, so that it could easily be given to unwilling patients. All observers were agreed that it did not act on the heart. The action was very slow, so that it was not so suitable for acute affections. It did not relieve pain, but it was unreplaceable in cases distinguished by motor restlessness, such as chorea. In mania it was best to give ½ to 1 gramme

during the day and another dose in the evening. After long-continued use the patients suffered from giddiness, so that they staggered in their walk. Patients declared that they felt stupid, they could not move their arms or legs properly. These symptoms disappeared when the medicine was stopped. Urethan, methylal, and hypnone, from their being unsafe or unreliable, had fallen into disuse. All comparison of these drugs was possible only to a slight extent. The sleep after sulphonal was most like the natural. With long continuance it was not without its effect upon the heart.—Berlin Cor. *Med. Press*, July 31, 1889.

Gairdner (W. T.) on the Treatment of Severe Chorea by Chloral.—The author in 1870 in treating an unusually intractable and serious case of chorea began using chloral, then a rather new hypnotic. By mistake sixty grains were given to the case, a girl of eight years of age. Symptoms of poisoning set in, and the critical state was not passed until the lapse of five hours. The choreiform movements entirely disappeared and did not return. The girl was discharged recovered in two months. He had continued to treat similar cases in this way ever since the good result obtained in his accidental experiment. Since then many others had found chloral extremely useful for the same purpose. The most recent writer to laud the drug in severe chorea was Dr. Bastian in an article in the *Lancet* of July 13, 1889. In all ordinary cases he should not think of resorting to it, since they readily yield to arsenical or other tonic treatment. But there are unquestionably a few cases in which the tonic regimen and tonic treatment fail, and others in which their action, though ultimately successful, is so slow as to be unsatisfactory; besides a very few in which the disease *per se* is alarming and apparently dangerous from exhaustion, present or proximate, so as fully to justify (not to say excuse) a much more active treatment. In all these three classes of cases he has habitually employed chloral, and since 1870 chloral *almost alone*. These, of course, have been almost among the worst cases in his experience; and practically these have included *all* the very bad cases. And, therefore, he declares in no single instance has chloral hydrate, with the comparatively modest and limited expectations he has formed of its value, wholly and absolutely disappointed expectation. It has not often *cured*, it is true, directly and at once, as in the case just narrated, but it has always had an important influence in controlling choreic spasm, and has rarely failed in placing the patient *in the way of cure* when followed up by hygienic and other remedies or by lapse of time, which in many such cases is *the* remedy. He recalls several cases of chorea in children so bad that he could not but regard them as having an element of present danger, which have yielded at once as a first step in the treatment to chloral hydrate, under which mainly the cure has been completed. Taking it all round, his experience of this remedy in chorea, while not without qualifications, is certainly not in accordance with the following expression of Dr. Sydney Ringer (*sub voce*): "Chloral *sometimes* restrains the voluntary movements of chorea, *but sometimes it is powerless*." It would be much more correct to say that chloral can almost always be depended on to control the movements of genuine chorea for the time during which its physiological action is fully maintained, but that it is sometimes inadequate to a permanent cure.—*Lancet*, Aug. 3, 1889.

Abbot (S. L.) on Urethan in Tetany.—The author had a severe case of tetany at the Massachusetts General Hospital, a 'longshoreman, aged forty-three. The disease had lasted six weeks. Having used urethan successfully in severe chorea, he determined to try its efficacy in this disease. Ten grains were prescribed to be given every two hours by day and fifteen at bedtime. After the second day the cramps had disappeared and did not return. Treatment was continued for nine days. He had heard of the patient nine months later, and he had remained in perfect health.—*Bost. Med. and Surg. Jour.*, Sept. 5, 1889.

Tait (L.) on Insanity Following Surgical Operations.—In a recent letter to the *Brit. Med. Jour.* (Aug. 31, 1889), Dr. Tait speaks as follows in criticising Dr. E. Denis' book upon this subject:

"I have now performed, so far as I can estimate, between 7,000 and 8,000 operations requiring the use of anæsthetics, and I have had anæsthetics administered in my practice for purposes not involving traumatism probably in 3,000 more instances, and I know of seven cases of sequent—not

necessarily consequent—insanity. Of course there may have been others not known to me, and I shall say fourteen cases to cover that margin of error.

"My own practice, therefore, does not yield a proportion of cases of insanity following operations larger than the general proportion of insanity in the adult female population; and if I include the cases of anæsthesia, it is probably considerably smaller.

"Dr. Denis says: 'En moyenne, on observe 2.5 cas d'aliénation mentale sur 100 opérations.' But if this had been the case all of us engaged in active operating practice would have felt the influence of the fact long ago. Personally, I have been struck by the occurrence of insanity after operations as being like the occurrence of tetanus—something to be met with occasionally, but not a matter to calculate upon. If I saw an insanity rate of 2.5 in my operations, it would be more striking than any death-rate in everything but my hysterectomies, and in that class I have already said I have never seen insanity follow in a single instance; and Dr. Bantock's experience amounts to practically the same result, for his exception cannot really be called one of insanity following an operation. As a *per contra*, I can point to at least thirteen cases where operations have cured insanity."

Leech (D. J.) on Hypnotics and Analgesics; Gordon (J.) on Urethan.—Dr. D. J. Leech (Professor of Therapeutics in the Victoria University, Manchester) contributed a paper on "Hypnotics and Analgesics," in which he stated that very many drugs had recently been introduced as hypnotics. Almost all of them were derived from the substances belonging to the methyl and ethyl series. He pointed out that the admission of chloral hydrate was not devoid of danger if large doses were given, since it tended to weaken the heart's action. The chloral habit had probably caused many deaths. After describing the effects of the various fresh hypnotics, and their freedom from danger, even in large doses, Dr. Leech alluded to the possibility which existed of producing new ones which might have even more beneficial effects than those they now knew of. The substitution of one kind of atom for another had a distinct effect on the influence of the compound produced. They now knew that the introduction of one group of molecules tended to produce a sleeping drug. It might be possible to find groups which relieve pain, and in this way a substance as powerful as opium, but without its ill effects, might possibly be built up chemically.—Dr. John Gordon (Aberdeen) described the result of a series of experiments with urethane. He said that he found it a valuable sleep-producing drug in cases of sleeplessness where there was no marked pain. It was highly useful in cases of hysteria, overwork, bronchitis, and pneumonia. He noticed, however, that in some cases it had a tendency to cause irritation of the stomach after prolonged action. When it acted he found that its action was always prompt, that the sleep it produced was pleasant, tranquil, and natural, and that the patient always awoke refreshed after its administration.—*Provincial Med. Jour.*, Oct. 1, 1889.

Woodward (M.) on Landry's Paralysis.—A case of that mysterious affection, "Landry's paralysis," recently occurred in my practice. The subject was a laboring man, aged thirty-seven, married, with three children. His wife informed me, beyond some trembling of the hands, he had been at work in good health. When I first saw him, with the exception of a feeling of weariness, there was an entire absence of symptoms; on my next visit, two days later, he was sweating profusely, and the hyperidrosis continued until he died. In a few days paralysis of the muscles of the lower extremities was complete, soon those of the trunk and upper extremities were involved; the breathing became difficult, and he died on the tenth day. The symptoms followed the course described in standard works except the sweating, of which I find no mention. The temperature remained normal, or nearly so, throughout, and the muscles flaccid.—*Br. Med. Jour.*, Nov. 3, 1888.

Folsom (C. F.) on the Early Stages of General Paralysis.—He cites at length a number of cases in which some transient deviation from the normal mental equilibrium, antedating by a considerable period any pronounced symptoms, had led him to make a diagnosis of approaching general paralysis, which had been subsequently confirmed by the disease fully developing. These cases also illustrated that in the early stage of the disease the motor disturbances might be

very slight or might altogether escape detection. That striking loss of muscular power or control generally regarded as a part of the disease was not always apparent until a later period. The mental symptoms were difficult to detect, but this could be more readily done in some vocations than others. For instance, the requirements for an orchestral leader being of so complex an order, the least failure was detected. In professional and business men a less degree of impairment would be recognizable than in mechanics. In routine employment, without much thought, a large degree of deterioration might exist unnoticed. In day-laborers an early diagnosis was impossible. The earliest signs of paralysis would probably be the slightest possible brain failure. If, for instance, a strong, healthy man at or near the prime of life, distinctly not of the nervous, neurotic, or neurasthenic type, showed some loss of interest in his affairs or an impaired facility in attending to them; if such a man became varyingly absent-minded, heedless, indifferent, negligent, apathetic, inconsiderate; if, while able to follow his routine duties, his ability to take up new work was, no matter how little, diminished; if he gave less willing mental attention and concentration, showed less power in conception, perception, reflection, or judgment; if there appeared lack of initiative, and exertion caused unwonted mental and physical fatigue; if the emotions were intensified or excited readily by trifling causes; if the sexual instinct could not be reasonably controlled and the finer feelings were even slightly blunted; if the person in question regarded with a placid apathy his own acts of indifference and irritability, and especially if at times he was able to see himself in his true light, and then suddenly failed to do so; if any symptom of cerebral vaso-motor disturbance became evident, however vague or variable,—the foregoing might be regarded as suspicious indications, though there might be more or fewer in any given case. The group of symptoms given might seem very striking, but were really compatible with the performance of usual duties and required careful and prolonged observation of the patient and painstaking interrogation of his family and friends for their detection. They would be recognized perhaps as much from the peculiar quality of the mental impairment, difficult to describe, as from its degree. These often antedated, at least in time of their recognizability, any physical symptoms. The latter, when they appeared, might be so slight as to be unappreciable for a long time except as an unusual sense of fatigue and weariness. Commonly there was loss of flesh. There were always elements of uncertainty in the early diagnosis of general paralysis, for there existed few forms of mental disease in adult life that it might not simulate in obscure cases. It might be confounded with Bright's disease, epilepsy, hysteria, lead or mercurial poisoning, cerebral complications, and so forth. Its relation with syphilis was too frequent to be accidental, yet it could not be classed as properly a stage of that disease, nor was it benefited by specific treatment. He did not deem the prognosis so hopeless as it was generally considered. The present methods adopted in treatment were really detrimental, and even when nothing but partial cure or marked amelioration could be hoped for such would be best achieved by methods which secured the patient absolute rest.—*N. Y. Med. Jour.*, Oct. 5, 1889.

Treatment of Insanity by Hypnotism.—At the last meeting of the British Medical Association this was the subject of a long discussion, the greater part of which is reproduced here:

Dr. Auguste Voisin, Physician to the Salpêtrière, Paris, made a communication on the treatment of insanity and neuroses by hypnotic suggestion, and on the application of the method to the moral and instinctive perversion of backward and imbecile children. He stated that until within the last few years no serious attempt had been made in this direction, and that it was generally supposed that the insane could not be hypnotized. Dr. Voisin had been able to develop this method in his hospital and private practice. Catalepsy ought to be carefully avoided, because the hypnotized individual ought to be able to preserve the use of his senses, especially of hearing. He was convinced that hypnotism was only useful when it was possible to make use of suggestion, and he was firmly of opinion that, as Braid had said, the hypnotic state originated in the nervous system of the hypnotized person. Having described the basis of hypnotic treatment and of suggestive therapeutics, Dr. Voisin detailed the various categories of the insane with regard to whom he had made observa-

tions. By this treatment he had cured persons suffering from hallucinations and delusions, and from disturbances of special and general sensation. Suicidal ideas and acute and furious mania had disappeared under the use of this method. Cases of insanity were cited which had only been calmed after several hours. The treatment had also succeeded in the mania and agitation observed during the catamenia. Patients in this category had even remained asleep for from six to eight days. The method had also succeeded in dipsomania and in morphinomania. Dr. Voisin had also been fortunate enough to cure obstinate cases of onanism in this way, and had applied the method *à la moralisation des enfants dépravés.* He had thus completely transformed their habits of thought, and had brought them to love the good, whereas formerly they had only loved the evil. He had also succeeded in curing amenorrhœa in the insane, which was a frequent cause of nervous and mental troubles; he particularly insisted upon this point as proving it was possible to influence the functions of the sympathetic system.—Dr. Yellowlees said his attitude of mind towards this paper was simply one of amazement. Here was something that cured mania, banished hallucinations, cured love of drink and morphine, stopped masturbation, improved the memory, made imbeciles wise, and bad folks good; moreover, it cured amenorrhœa, and the patient menstruated as directed. It resembled nothing so much as the waving of a conjurer's wand, and saying to disease, "Begone." Moreover, in nine tenths of the cases the cure was permanent. If all this were true, their vocation was gone, and they must seek some other profession. Dr. Voisin must not deem them disrespectful if they were a little incredulous as to these wonderful results. It might be that there was something in the vivid Gallic nature that we had not here, or something in Dr. Voisin's method that they did not know. Certainly they had seen no such results from hypnotism here, and certainly he had never heard of results so amazing as those enumerated in Dr. Voisin's paper. Nothing would be so satisfactory to the section as to get a demonstration of his method from Dr. Voisin at the Wakefield Asylum next day, and he would earnestly ask for this.

Dr. Langdon Down had witnessed some cases of hypnotism when the patients declared that, under the influence of suggestion, control over the bowels in constipation and over the uterine function could be obtained. Dr. Tuckey had found it successful in the treatment of dipsomania, masturbation, occupation neuroses, such as writers' cramp, and various neuralgias. The Rev. Arthur Tooth, of Woodside, Croyden, was employing hypnotic suggestion with much success in his institution for inebriates. Out of the first hundred cases he only failed to influence hypnotically twenty-one patients. But his experience in the treatment of melancholia by hypnotism had so far been disappointing. Only six persons out of the hundred were sufficiently deeply influenced to be susceptible to post-hypnotic delusions or suggestion. The common idea, therefore, that the patient was, subsequently to hypnotism, a mere tool in the hands of the operator, was erronous in the immense majority of cases. Dr. Ireland thought that perhaps Dr. Voisin had made too sweeping claims for the success of his method of treatment. He himself could not hope that nine tenths of the patients so treated would derive benefit, but he had no doubt that in some cases much good might result from hypnotism. Braid, of Manchester, had claimed cures quite as startling as those stated by Dr. Voison. He published a case in which milk was brought into one mamma in a woman, the other remaining flaccid. There were instances of women being violated when in the hypnotic condition. He, however, did not think that because the remedy was capable of abuse it should be proscribed. The same objection might apply to chloroform. Dr. Percy Smith in the past winter had subjected sixteen patients in Bethlem to experiments, with the assistance of Dr. A. T. Myers, who obtained the services of a professional hypnotizer. The following rules were laid down: 1. That any experiments of this sort in the insane should be entirely directed to a therapeutic end, and not merely to elucidate physiology. 2. That the term "mesmerism" should be avoided in speaking on the matter before patients. 3. The patient not to be alone at the time, and, if a female, that a nurse should always be present. He was obliged to state that the results had been almost entirely negative—in fact, he had not been able to get insane patients into the hypnotic state. It seemed almost impossible to secure the necessary attention. He did

not think it necessary to fatigue the meeting with details of all the cases, though it was important to publish failure as much as success. He briefly mentioned the methods used, and suggested that in all probability patients in France were more susceptible than in England. He thought that the matter should not be put off lightly, and that evidently more experience was needed before a final opinion could be given as to the value of hypnotism in the treatment of insanity.—*Brit. Med. Jour.*, Sept. 21, 1889.

The International Congress on Hypnotism.—At this congress, recently held in Paris, over a hundred medical men, French and foreign, responded to the summons of the organizing committee. M. Dumontpallier, the president, at the opening sitting, traced rapidly the history of scientific hypnotism, the progress of which was in a large measure due to the researches of the school of the Salpétrière and of that of Nancy, but the popular knowledge of which in the profession dated back to very recent days only. The study of scientific hypnotism, said the speaker, began in 1876 only, when a commission was nominated by the Biological Society to report on the experiments in metallo-therapy of Burq. The recognition of certain effects produced by metals led the commission to the study of hypnotism, which produced analogous phenomena. M. Dumontpallier, at the Hôpital la Pitié, and M. Charcot, at the Salpêtrière, carried on this inquiry. Then the Nancy school, directed by Liébeault, Bernheim, and Liégeois, worked out one branch or factor in the hypnotism—viz., suggestion,—which it made peculiarly its own. Indeed M. Bernheim endeavors to show that under suggestion may be included nearly all the hypnotic phenomena. It is undoubtedly a powerful element, but many other procedures and physical agents may be used to bring about the hypnotic state independently of suggestion. Thanks to the works, then, of Ladame and others, hypnotism now finds its place in the academies, and no longer meets with opposition from scientific minds. It was still, however, necessary, in order to place this progress on a solid basis, that all experiments should be conducted with scientific reserve and closely criticised, and to consider nothing as a demonstrated fact unless it were confirmed by all or the majority of inquirers. Such in *résumé* was the opening address of the president. The first question which was put before the meeting for consideration was: "The prohibition of all public performances in hypnotism, and the necessity of putting hypnotism under legal control." Finally the proposition was put to the vote and carried, and to it was added the following resolution, which was also carried—viz.: "That it is desirable that the study of hypnotism and its therapeutical applications be introduced into the curriculum of medical education. MM. van Renterghem and van Eeden, of Amsterdam, next communicated the results obtained in the treatment of 414 cases made up of organic diseases of the nervous system, neurotic, mental, and neuralgic cases, etc. The method adopted was the Nancy one of suggestion. In 71 cases there was no result, in 92 slight amelioration, in 98 marked amelioration, and in 104 cases cure; 57 cases were not worked out. After this the congress proceeded to the discussion of the second question—viz.: "What is the relative value of the different methods of bringing about the hypnotic state and of augmenting suggestion from a therapeutic standpoint?" M. Bernheim, in discussing these points, said that to define hypnotism as induced sleep was not sufficient, for all hypnotized subjects do not sleep. Some have profound sleep, with amnesia on waking; others also sleep deeply, but recollect their hypnotic period; a third category fall into a light sleep only; and, finally, there are others who do not sleep, or believe they do not. The degree of suggestibility varies with each one of these groups, and is very high in the first; the second are also subject to fairly complete suggestion, but in the remaining groups it is incomplete. For example, one can obtain suggestion of movements and sensation, but not hallucinations. A subject may, however, pass from one to another of these categories. The hypnotic condition, then, is not mere sleep, but a peculiar psychical state, the sleep indicating a profound condition of suggestibility only.—*Lancet*, Aug. 31, 1889.

Arlidge (J. T.) on the Sources of Lead Poisoning.—This metal exerts its poisonous influence under three forms, namely: 1, lead in the solid form, as lead ore, as metallic lead, and as an alloy; 2, in the form of its salts, whether in powder or solution; and 3, in a mixed form, with oils and fluxes. In the form of ore it is

productive of plumbism among the miners and smelters, being injurious to the former chiefly in the shape of dust, and to the latter in that of vapor. It is, too, as a vapor that it produces its noxious effects among the makers of the oxides of lead in the process of calcination. In the case of metallic lead, plumbism is a result among those who frequently handle it, such as file cutters, makers of leaden pipes and of shot and lead-foil, plumbers, and type-casters. In type it enters as an alloy, and as such at times affects injuriously compositors. In the shape of an alloy it proves mischievous with pewterers, the makers of soft metallic capsules and of inferior German silver or pinchbeck. Further, metallic lead becomes indirectly the cause of illness when employed to form utensils for the storage or preparation of articles of food or of snuff and tobacco, or in the construction of pipes for conducting or drawing off fluids. But cases of poisoning are caused more frequently by salts of lead, especially white and red lead. The writer also referred to the accidental introduction of the metal in articles of food or in drinking-water under conditions so well studied by sanitarians; in porter, beer, cider, and lemonade, or fruit juices, any of which may have stood in contact with lead or its alloys in the form of pipes or capsules; or in bottles carelessly cleaned with shot; in solid, but moist or deliquescent, food preserved in lead-foil, or so-called tin cans with soldered joints; or in food cooked or salted in vessels on the surface of which lead occurs as a glaze, or else which have it enter into their structure.—*Med. Rec.*, Sept. 7, 1889.

Stewart (James) on Inebriety among the Cultured and Educated Classes.—In a page upon this subject the author gave a *résumé* of observations based upon twelve years' experience in the treatment of inebriates. He called special attention to the pathological condition of the cerebral tissue in inebriety, a loss of brain substance as real as the loss of a portion of a finger sliced off accidentally with a knife. Inebriety was a physical disease as clearly marked as many other diseases, and must, to be successfully treated, be dealt with in as scientific a manner as these other maladies. New and sound brain tissue must be built up before a cure could be effected. This required a considerable time, the shortest term being twelve months. Dr. Stewart concluded by stating as his opinion that: (1) Inebriety is a lesion of the brain which has gone so far as to affect the will-power. (2) Successful treatment based on this pathological dictum must include the absolute cessation of alcoholic drinking. (3) There is no danger in the sudden and complete withdrawal of alcohol if the case, no matter how severe, be in the hands of a skilful physician able to personally direct the hourly treatment from the first. (4) The physician undertaking the charge of such cases ought to be himself a total abstainer, so that moral treatment by example might supplement therapeutic remedies. (5) Permanent recovery need not be hoped for unless both lines of treatment be pursued systematically—during an uninterrupted period of twelve months—in a home from which alcohol is excluded. (6) So-called "cures" effected by bark, strychnine, and other specifics have not proved permanent. (7) The permanence of a cure depends greatly on the after treatment pursued subsequent to the patient leaving the "home." The family of the inebriate should all become total abstainers, no alcohol being allowed into his or her house except as a drug prescribed by a medical man and dispensed in a medicine bottle.—*Med. Press*, Jan. 9, 1889.

Insanity from Use of Ganja in Bengal.—In Bengal, among the predisposing and exciting causes of insanity, ganja takes the place of alcohol. Its effects, though equally violent in many instances, are much more evanescent, and its habitual use does not lead to the same organic tissue changes. A very large proportion of the graver crimes are committed under its acute influence, but under confinement and deprivation of the drug the mania which it causes rapidly subsides, and leaves the man a quiet and trustworthy inmate, with little tendency to relapse in the absence of the drug for the remainder of his life.—Extract from editorial, *Lancet*, Nov. 17, 1888. [*Ganga, gunjah, bangue, beng, subjee*, supposed to be the nepenthe of the ancients, consists of the largest leaves and capsules of *cannabis Indica*, mixed usually with other substances like sugar, areca, etc., and is used for chewing and smoking.—F. P.]

Hopkins (H. R.) on the Treatment of the Insane.—Dr. Hopkins, in a discussion before the Buffalo Medical Association, June, 4, 1889, upon the above subject, presented ideas so in accord with those of the writer of this abstract, that he cannot

refrain from assisting in their diffusion. The most important of these is that of opening general hospitals to the reception of the curable insane, as has been done in Victoria, Australia. The remarks bearing upon this subject are as follows:

"This is the year 1889, and yet it is necessary to call the attention of this society, and of the medical profession which this society represents, to the fact that in the management of the insane we have retained certain demoniacal residua. Our statutes and our usages still provide that before an insane man can be subjected to suitable treatment, the machinery of the courts has to be invoked, and he has to be committed to an asylum, to be sure, and yet this asylum is abundantly supplied with locks, bolts, bars, handcuffs, strait-jackets, camisoles, and various methods of treatment hardly compatible with the idea that the insane is only a patient needing medical treatment. Is it not time, Mr. President and gentlemen, that the medical profession asserted itself and recognized, in fact as well as in theory, that the insane is not demoniac, but only ill? Could any thing be more absurd than for a medical man of this day to apply to the courts for permission to treat a case of inflammation of the eye, to place a patient suffering from inflammation of the eyes in that condition where injurious influences are to be excluded from him; or, in case of a fractured femur, to invoke the machinery of the law to enable him to place such restraint upon the patient as experience has demonstrated is necessary to his proper recovery? For myself I can see no lack of similarity between the requirements of one suffering from an inflammation of the eye, or suffering from a fractured femur, and one suffering from mental disease; and it seems to me that it is for the medical profession to assert that it has no conception of an insane man other than as a patient requiring relief, and that the medical profession is in a situation to demand that there shall be no circumlocution, no embarrassments placed between the most enlightened treatment and the suffering citizen in need of such treatment.

"This brings me to a suggestion which I would like to make to the society, and that is, that it is not expedient that the care and management of the insane of any community be placed in the hands of a few individuals of the medical profession. In my judgment the members of the medical profession at large are the safest custodians for this responsibility, and I would suggest for the consideration of this society the propriety of recommending that every hospital have attached to it a suitably prepared ward for the reception of the acutely insane. To these wards, so equipped, patients should be admitted with no more circumlocution than pertains to the admission of patients to the surgical ward, the lying-in ward, or any other department of a well-equipped hospital. If statistics have ever established any fact in medicine, they have established the truth that early treatment in the history of insanity exercises the most hopeful influence over the case.—*Buf. Med. and Surg. Jour.*, Aug., 1889.

Savage (G. H.) on Massage in Insanity.—The author, in a paper on this subject, said that of late there had been too great a tendency to treat all cases of neurosis by massage. This treatment was not only of no use, but was really harmful in some such cases. It might be taken for granted that it was rarely if ever useful in ordinary cases of insanity; in cases of emotional self-consciousness it was bad, both the solitude and the bed being contra-indicated. In hypochondriacal states it was generally harmful, and in most cases of active melancholia it was not useful. Its chief use was in those cases in which the mental depression was associated with physical weakness, loss of flesh, and deficient action of the gastro-intestinal tract. The massage should be continued as long as the general health was feeble, and as long as the appetite was bad. The object was like putting salt in the food given by stomach tube to create a desire for food, and then to supply it in a suitable form and quantity. He related a specially interesting case of melancholia cured after four years of profound depression.—*Edinb. Med. Jour.*, Sept., 1889.

Prince (Morton) on Malaria as a Cause of Degenerative Diseases of the Spinal Cord.—The author spoke of the frequency of tabes and other spinal degenerations in cases which also presented a history of malaria. The first case he had recorded was one of locomotor ataxia with typical tabetic crises before each malarial chill. Another had gastric crises regularly once monthly, and another, crises beginning with rigor and followed by diarrhœa—this occurring every three weeks. The lat-

ter case had been diagnosticated as malaria by the family physician. Altogether, the author reported in detail six cases showing the coexistence of tabes with malaria, and six cases where the malarial history was associated with disseminated sclerosis. Besides these, he had notes of three other cases of multiple sclerosis, two of locomotor ataxia, and one of lateral sclerosis with a similar relation. Generally the malarial poison was present in the system previous to the development of the spinal symptoms. He pointed out coincidences in the course of syphilis and malaria, such as the slowness of action of the poison and amenability to treatment; and also called attention to the relation of the syphilitic virus to tabes. He had found but little to support his etiological theory in literature. Erb, following Schulze, stated that tabes may occur as a sequel to intermittent fever. Tuezek had proven that tabes could be caused by the ergot parasite. Many nervous disorders are undoubtedly due to malaria, such as neuralgias, anæsthesias, severe psychoses, etc. He alluded to the deposition of pigment in the brain in some cases of pernicious malaria. It would be very important for many army pensioners if it could be definitely determined that tabes and sclerosis might be sequelæ of malaria. —*Bost. Med. and Surg. Jour.*, August 22, 1889.

OCCASIONAL REPORT ON DERMATOLOGY.

BY CONDICT W. CUTLER, M.D.

Bulkley (L. D.) on Recent Advances in the Treatment of Diseases of the Skin.—The first advance in the treatment of diseases of the skin is due to our ability to better diagnose these diseases; physicians no longer class all skin diseases either as syphilis or eczema.

The second point of advance lies in appreciating thoroughly the particular condition or stage of the eruption, and in treating it accordingly.

The advance in the treatment of skin diseases in the past five years has been very rapid, and among the most recent is the *mechanical therapy*. The *curette* is very serviceable in the treatment of lupus and removing epitheliomata, warts, and excrescences. The *cutaneous punch* is of value in removing epitheliomata, powder grains, moles, and sections of tissue for microscopical examination.

Multiple scarification is useful in lupus, rosacea, and some nævi.

Electrolysis yields brilliant results in removing hairs, in destroying hairy moles, nævi, and producing absorption of tumors.

Galvanization is most valuable in checking pain of herpes zoster and dermatalgia, and will control pruritis and sometimes cure eczema.

Among the new remedies which have been employed of late is *ichthyol*. This drug when used in the form of a 2 to 5 % solution or ointment has yielded good results in the treatment of ulcers and moist eczema.

Resorcin, used either in solution or ointment in strength from 3 to 5 %, has proven very successful as a parasiticide, and in the treatment of seborrhœa, eczema, acne, and pityriasis capitis.

Thick ointments pressed upon and into the meshes of muslin are called *pflaster mulle*, which serve to keep a fixed dressing in localities where we wish to produce maceration. Thus in thickened patches of eczema a 10 % to 20 % salicylic-acid plaster, a mercury plaster in reducing the late lesions of syphilis, and a 10 % chrysarobin plaster in psoriasis, all give good results.

Fixed dressings may also be secured by incorporating our drugs in flexible collodion, liquor gutta-perchæ, or glycerine jelly, made by boiling one part of gelatine with three of glycerine and a little water (must be heated each time before using), and painting over the affected areas with these preparations.

Preparations of petroleum have been used much of late as the fatty basis for ointments, and when used simply to lubricate the skin they act very well, but when it is desirable to form a protective covering to the skin they are far too soft and should not be used. As a basis for such ointments there is none better than the unguentum aquæ rosæ of the pharmacopœia.

Naphthol has of late been used largely in the treatment of scabies in the form of a 10 % ointment and with excellent result. It is also useful in psoriasis.—*Journal of the American Med. Association*, September 7, 1889.

Molenes on Gonorrhœal Erythema.—Most men still ascribe to the absorption of copaiba and cubebs those eruptions which appear in the treatment

of gonorrhœa. True erythema may occur from the use of these drugs, but it is rare, and the real cause lies in the gonococcus of Neisser. The erythema seldom occurs when these drugs are used for other diseases than gonorrhœa. Even in gonorrhœa when the eruption is present if these drugs be continued the erythema rapidly disappears. The author has noticed the appearance of these erythematous eruptions in many cases of gonorrhœa when no drugs at all have been used.—*Edinburgh Med. Journal*, September, 1889. From the *Ann. de Dermat. et de Syph., No.* 2, 1889.

Bartens on Transplantation of Skin from a Corpse to a Living Person.—Dr. Bartens has successfully transplanted the skin of a corpse to a living person who had been severely burned, leaving large granulating surfaces. His method of procedure was as follows :

On December 13th a lunatic died in the hospital of pyæmia following a compound fracture of the arm, and about twenty minutes after his death two large, good-conditioned flaps were removed from the legs of the corpse. These were laid in warm water to which a little salt had been added, and then were taken to the division of the hospital (two or three hundred yards away) in which the scalded boy lay. These flaps were then carefully washed and cleansed of their subjacent fatty pannus ; that done, they were divided into smaller pieces of from one cm. wide to about one to two cm. long (the ulcerated surfaces of the boy's legs had been cleansed in the same manner as the flaps in the meantime) ; then these pieces were laid on to fit as nearly as might be, dusted over with iodoform and covered with batting, and compresses applied. This whole proceeding took about one hour and a half from the time of the death of the old man ; there were twenty-eight pieces applied in all,—as it happened, too, fourteen on each limb.

On the 19th December, the bandages were removed for the first time, and it was found that there was union of twenty-four of these grafts.—*Brooklyn Med. Journal*, September, 1889.

Verneuil on the Identity of Erysipelas and Acute Lymphangitis.—Verneuil bases his belief on the identity of erysipelas and acute lymphangitis for the following reasons :

1. The similar anatomical relations of the two diseases; acute lymphangitis attacking the trunks of the lymphatic system, the capillaries being affected in erysipelas, while in both diseases the glands are attacked.

2. The similarity of the course in the two diseases.

3. The onset of the disease is similar.

4. The clinical difficulty presented in many cases of distinguishing the one from the other.

5. The micro-organisms found in the two diseases are the same.—*Glasgow Med. Journal*, Sept. 1, 1889.

Bulkley (D. L.) on Unusual Methods of Acquiring Syphilis.—Dr. Bulkley refers to sixty-six cases in which the chancre was extra-genital, and divides the modes into which non-venereal infection may take place into three groups :

1. *Syphilis economica*—in which the disease is transmitted in the ordinary relations of domestic and industrial life, as by spoons, knives, jugs, tobacco-pipes, cigars, articles of wearing apparel, and so on ; by musical instruments ; by personal transmission, as by kissing, biting, etc.

2. *Syphalis brephotrophica*—in which the virus is conveyed in suckling or attending to infants.

3. *Syphalis technica*—in which transmission occurs in connection with various forms of body service, medical and surgical. Here the operator may be the victim, or he may be the syphilifer, or simply the medium.—*Glasgow Med. Journal*, Sept. 1889.

Wackez on Creolin Eczemas.—In seventeen cases which were treated with creolin dressings, seven of them suffered with eczema, which usually began about the edges of the wound on the second day, and was accompanied by rise of temperature, vomiting, headache, lymphangitis, and non-union. The strength of the creolin solution used was 1 to 1,000. The urine contained phenol.—*Therapeutische Monatschrift*, June, 1889.

Jackson (G. T.) on New Dermatological Remedies.—The new drugs which Schwimmer reports upon (*Wien. med. Wochenschrift*, 1889, No. 3) are salol, oxynaphthoic acid, salicylate of mercury, and anthrarobin. *Salol* may be used as a substitute for iodoform in proportion of two parts of salol to one of starch. *Oxynaphthoic acid* is best used in a ten per cent. ointment with green soap and lard in scabies and prurigo. It does not irritate

the skin and is very efficacious. *Salicylate of mercury* is found most useful in treatment of constitutional syphilis in three-quarter grain doses t.i.d. It is apt to cause stomatitis, erythema, and urticaria. *Anthrarobin* may be used as a substitute for chrysarobin, but is less active or irritating. In parasitic diseases it acts well in ten per cent. solution in collodion.—*N. Y. Med. Jour.*, Oct. 12, 1889.

Jackson (G. T.) on Hydroxylamine in Psoriasis.—The advantages of hydroxylamine are that it does not irritate the skin as much as pyrogallol or chrysarobin, that it is cheap, that it does not stain the underclothing, and that it is quite as rapid in its curative effects as the drugs just named. It took from four to six weeks to remove all traces of the disease in an inveterate.

Hydroxylamine may prove itself to be a very irritating substance, its irritant action varying with different skins. It is necessary in some cases to use a solution not stronger than 1 to 500 and increase the strength p. r. n.

It should always be remembered that, should symptoms of irritation show themselves, the remedy must be stopped, and some soothing application made until the irritation is reduced, when the remedy may be resumed.—*N. Y. Med. Jour.*, Oct. 12, 1889.

On the Purpuras.—Under the general head of purpura, one finds subdivisions of purpura simplex, purpura rheumatica or peliosis rheumatica, purpura hæmorrhagica. We have, besides, purpura nervosa or myelopathic purpura, purpura urticans, purpura papulosa, purpura scorbutica, or scurvy, and the various cachectic, senile, infectious, and mechanical purpuras.

From all this it may easily be seen how little of definite significance the term purpura possesses.

Leaving out from the ordinary purpuras the purpura scorbutica, since that is a well-defined malady of quite well-known origin, the forms of purpura which are most commonly seen in this country are purpura simplex, purpura rheumatica, purpura hæmorrhagica, and certain types occurring in cachectic alcoholic subjects. The simple purpuras include those mild types occurring usually in the aged, without articular or gastro-intestinal disturbance. Purpura rheumatica is often associated with purpura hæmorrhagica, but in the former the joints are severally affected and in the latter the mucous membranes.—Editorial, *Med. Record*, Oct. 12, 1889.

Quinquaud on Treatment of Ringworm of the Scalp.—The treatment consisted in the application of a one per cent. ointment of protochloride of iodine in lanoline. Every second day the head is sprayed with warm water, and then it is dried and rubbed for some time with this ointment. It is possible by this means to cure ringworm of the scalp within a few months without resorting to epilation.

Another plan was to cut the hair very short, shampoo the head every morning, and then apply a lotion of biniodide of mercury, 3 grains; bichloride of mercury, 15 grains; alcohol, 10 drachms; distilled water, 8 ounces. After that the affected parts are scraped with a special form of curette. At the end of a week, during which time this process may have been repeated once or twice, the hairs are pulled out. Epilation is accomplished much more easily now, since the previous treatment has made the hairs much less brittle. The scraping is repleted every week or two, and in the intervals a plaster of the biniodide and bichloride of mercury is applied. A cure is thus obtained in three or four months. The children usually bear the scraping very well.—*Med. Record*, Oct. 12, 1889.

Bloom (I. N.) on Hypodermic Injections of Insoluble Mercurials.—France, Germany, Austria, and Italy give universal testimony to the good effects of hypodermic injections of the insoluble mercurials in both early and late syphilis. The value of the treatment, however, has been called in question from a practical standpoint,—first, on account of the pain produced, and, second, on account of the abscesses which not infrequently resulted. By strict antiseptic precautions the number of abscesses produced have now been reduced to about two per cent. The drugs used have been calomel, gray oil, tannate of mercury, and the yellow oxide—the first- and last-named, however, are the mercurials usually used. Strict antiseptic precautions should be used, and the site of injection just behind the trochanter major. The drug should be held in suspension either in water, gum arabic, or oil of vaseline in proportion of 30 to 3 (if the yellow oxide is used), and about 15 (minims) of this injected at one time, and repeated in five to seven days.—*American Practitioner and News*, Sept. 14, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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REPORT ON OBSTETRICS.

Phillips (John) on the Treatment of Fibromyomata Complicating Pregnancy and Parturition.—The modifications which fibroids may produce in the course of pregnancy and labor are many; under the former may be classed such accidents as hemorrhage, abortion, and localized peritonitis, with the consequent formation of adhesions with various organs, such as the bladder, rectum, and liver; while under the latter we have mechanical obstruction to the passage of the fœtus through the pelvic canal, often reaching so serious an extent as to necessitate the Cæsarian section or the Porro-Cæsarian operation. Fœtal malpresentations and malformations also are not uncommon, besides certain changes in the tumors themselves, such as morbid softening or gangrene from torsion of the pedicle. Sterility is most often the rule in women afflicted with fibroids. Marion Sims collected 605 cases of sterility and found 119 of these with fibroids. Lefour noted 324 sterile women out of 990 with this complication, or 1 in 3.05.

In sub-serous fibroids, considerable enlargement may be produced by the onset of pregnancy, besides which certain physical changes both in position and shape occur as the uterus rises out of the pelvis. In the interstitial variety the tumor partakes sometimes to an enormous extent in uterine hypertrophy.

The chief symptoms which require treatment and management during pregnancy are:

1. Great pain, often excruciating in character and liable to exacerbations; this is more noticed in the sub-serous and interstitial forms.
2. Emaciation and pallor, with development of a peculiar aspect.
3. Continual and irrepressible vomiting.
4. Excessive distension from rapid increase in size of the tumor, or the presence of fœtal hydramnios or tumors.
5. Severe and repeated hemorrhages, chiefly in the sub-mucous variety, and corresponding with what would otherwise have been a menstrual period.
6. Compression phenomena, more especially if the tumor has caused ante- or retro-version, or if its lower portion has become incarcerated in the pelvis, *e.g.*, vesical and rectal troubles, vulvar œdema, etc.

The complications requiring treatment during labor appear to be fœtal malpresentations, placenta prævia, premature rupture of the cord, and rarely rupture of the uterine walls.

The various methods of treatment are:

1. Induction of premature labor.
2. Forced reposition under an anæsthetic.
3. Gradual hydrostatic pressure.
4. Enucleation *per vaginam*.
5. Version, forceps, and craniotomy.
6. The varieties of abdominal section.

The author then discusses with some detail the several methods of treatment in the light of both his own experience and

of that of others. His conclusions show that whether fibromata complicate the pregnant, parturient, or puerperal condition, they add considerably to the danger already existing. Operative interference is very often necessary and, whatever be its kind, is attended by a high mortality. The operation to be selected differs in each case, and there is no class of cases in existence in which fewer rules can be laid down for the guidance of the practitioner. Fibroids are often very intolerant of handling, and hence, unless absolutely necessary, no digital manipulation should be carried out.

The mortality, both maternal and fœtal, is very large. Version seems to be particularly fatal to both mother and child. The bruising of the tumor by the necessary manipulation is the probable explanation of this result.—*Practitioner*, Dec., 1888.

Mixter (S. J.) on a Case of Porro's Operation, Performed on Account of Multiple Myomata.—The patient was thirty-eight years old, a well-developed and fairly well-nourished Irish woman. The labor pains came on regularly and with the usual frequency. The abdomen, on the first examination, was observed to be much distended and very irregular in outline. On palpation it was evident that there was something more than the ordinary pregnant uterus in the abdomen. Above the pubes could be felt a rounded mass, the size of a fœtal head, and extending up from this to the margin of the ribs in the right hypochondriac region was a tumor, oval in outline, and evidently the uterus. Fœtal parts could be felt through the uterine wall, and the patient said that all fœtal motion had been felt in this part of the abdomen. The fœtal heart could be heard on the right side, opposite the umbilicus.

In the left hypochondrium was another mass, hard, rounded, and smooth, separated from the uterus by a sulcus, quite marked in the abdominal wall and still more distinct on deep pressure. This mass extended up under the border of the ribs, and the percussion note was flat over the whole abdomen except in the sulcus above mentioned, where it was tympanitic. Two other hard nodules could be felt through the abdominal wall, one near the umbilicus, about the size of a hen's egg.

Examination by the vagina showed a solid, immovable mass, filling nearly the whole pelvis. The finger could with difficulty be passed between this and the pubis, and a partially dilated os could be felt.

An immediate laparotomy was decided on, as there seemed no reason to believe that the firmly impacted mass in the pelvis would move up to allow the passage of the child.

An incision was made in the umbilicus, and the mass exposed. On introducing the hand into the adominal cavity a firm, solid mass could be felt, springing from the fundus of the uterus and extending upward and to the left, and adherent to omentum and intestines. The adhesions were clamped and divided where necessary, and the whole mass was turned out of the abdomen. During the manipulations a rent was made in a venous bridge connecting the uterus and fibroid, which gave rise to a profuse hemorrhage, easily controlled, however, by pressure. The tumor filling the pelvis could now be seen, and was with great difficulty dragged upward sufficiently to allow the wire écraseur to be placed about the cervix, below it, but without constricting it at all. Both of the large tumors presented yellow areas on their surfaces. Two smaller tumors were situated on the front of the uterus. The anterior uterine wall appeared to be thin, and was not apparently the site of the placental insertion. An opening was therefore made at this point, through which the child was delivered. The cord was clamped with forceps and divided. The uterus contracted rapidly as its contents were expelled. The uterus was then amputated, the broad ligaments were tied separately, and the abdominal wound closed. No attempt was made to stitch the peritoneal surfaces of the stump and abdominal wall together, as they were held firmly in apposition by the tension of the edges of the wound. The child weighed nine and a half pounds and was strong and active. The patient made an uninterrupted recovery and suffered no more than after a normal labor.—*Boston Medical and Surgical Journal*, Nov. 8, 1888.

Bond (A. K.) on a Fatal Case of Double Phlegmasia Dolens.—The patient was a mulatto woman, thirty-three years of age, well formed and apparently healthy. She had one child about eighteen months old. The woman was delivered after a rapid labor, before the physician could reach the house. He was sum-

moned thirteen days later, and found a circumscribed pneumonia in the left supra-capsular region. She was treated for a month, and was relieved from the symptoms of pneumonia, but her general condition remained very poor. A month and a half after delivery, she began to suffer, in addition to the lung trouble, from severe pain in the left hip, above and a little behind the great trochanter. Two months after delivery the left leg began to swell, from the groin downward to the foot. The tissues in the groin became hard and knotted, and very painful. The pain came then a day or two before the swelling, and extended along the line of the femoral artery. The tissue of the limb became more and more tense until the climax was reached, when they pitted on pressure. The temperature raised between 102° and 103°. Two weeks later the right knee began to swell, as the left had done, the swelling being accompanied by pain behind the great trochanter and in the groin. Four days later bed-sores appeared. The left leg was now nearly well, the right pitted on pressure up to the knee, but above was too tense to pit. The whole limb was painful when touched. The face was extremely wasted. The patient died twelve weeks after delivery and four weeks after the swelling first appeared. The immediate cause of death was considered to have been thrombosis of the right side of the heart or pulmonary artery.—*The Medical Register*, March 16, 1889. ELISABETH STOW BROWN.

OCCASIONAL REPORT ON DISEASES OF THE EAR AND EYE.

BY A. T. MUZZY, M.D.

Barr (Thos.). Investigations as to the Hearing of School Children.—Over 9,000 children have been examined in the schools of the following cities—New York, Stuttgart, Bordeaux, Munich, and Glasgow, and the average of defectively hearing pupils is 26 % plus. As a comparison test between children who were regarded as bright and those considered backward and dull scholars, teachers were requested to make a selection of seventy of each group. And the results of the examination of the two sets show *twice as many with defective hearing among backward children as among the forward children.* Some of the advice given to teachers would be: Keep in mind the liability of existing impairment of hearing in the backward children. Children known to be suffering from defective hearing should be given seats nearer the teachers, and with their best ear towards the desk. When the defect is considerable or extreme, they should be taught in separate classes. All boxing of the ears of children should be stringently prohibited.—*Brit. Med. Jour.*, Sept. 28, 1889.

Cohen (Otto) on the Form of the Orbit in Myopia.—Stilling is of opinion that a constant pressure on the eyeball is exerted by the superior oblique and the inferior rectus muscles in near work, favoring thus the growth of the eye in the antero-posterior direction. The influence of the shape of the orbit is easily understood. If the orbit be low, with the consequent deep trochlea, the tendon of the superior oblique will, more or less, lie on the globe compressing it, which is not the case when the orbit is high. Measurements taken of the orbit in 134 myopic eyes, at a Strasburg school, gave a low orbit in 114, and measurements of 200 hypermetropes and emmetropes gave a high-arched orbit in 166. Dissections of 20 orbits further showed actual compression of the globe by the tendon of the superior oblique muscle in low orbits.—*Arch. Ophth.*, New York, Sept., 1889.

Gessner (C.) on Enophthalmus Traumaticus—Only a few cases of enophthalmus are recorded, some six besides those occurring in cholera. The cases of a traumatic origin have recently presented themselves. All were miners, and during their work were struck by masses of coal that rendered them unconscious, part of the violence being expended on the supra-orbital ridge. After the immediate symptoms of swelling and inflammation subsided the injured eye was markedly smaller and deeper set than its fellow. In two the acuteness of vision was unimpaired. In all scars were left along the supra-orbital margin. Microphthalmus can be excluded on account of the equality of the cornea, its refraction, and the acuteness of vision. The retrobulbar atrophy is probably due to the orbital injury, and the periostitis consequent upon that, with the following cicatrization in the retrobulbar

cellular tissue. The muscular insufficiency and sluggishness is due to the deeper position of the eye.—*Arch. Ophth.*, New York, Sept., 1889.

Theobald (S.) on Veratria in Errors of Refraction.—For some time I have employed the oleate of veratria as an application to the forehead and temples for the relief of asthenopia and the headaches that result from accommodative strain, and have found it efficacious in many cases. I have also used it as a preliminary to examination in cases of astigmatism. It neither dilates the pupil nor paralyzes the accommodation, yet it quiets the irritability of the ciliary muscle, especially the radiating fibres, thus lessening a tendency to a symmetrical accommodation. Its action is sometimes quite slow. It is most conveniently used in the form of an oleate, which I use of a strength of 10 per cent. It need be applied but once a day, preferably in the morning, after washing, in minute quantity. It is necessary to caution patients to wash their hands carefully, to prevent transferring any of it from the forehead to the eyes by hand, handkerchief, or towel, as it causes very persistent irritation of the conjunctiva. In rubbing the temples, care should also be taken that it does not approach the eye as it spreads. In general, the local burning and itching it produces are not unpleasantly severe, though in a few cases complaint of this has been made. And the skin increases a tolerance for it. It may even be necessary to rub the skin with a rough towel before application of the oleate is made. After glasses have been prescribed, its use occasionally is decidedly effective in relieving any traces of asthenopia.—*Am. Jour. Ophth.*, Aug., 1889.

Noyes (H. D.) on an Operation for Some Extreme Cases of Entropion of the Upper Lid.—Putting the finger under the upper lid, and stretching it tight, a blunt-pointed knife is passed flatwise at the middle of lid, beneath the skin sufficiently to reach above the superior border of the tarsal cartilage, then turning the edge of the knife upon the finger, all the tissues, muscular, tarsal, and conjunctival, are divided, leaving only the skin. The wound gapes to the extent of 3 *mm.*, and healing is allowed to go on without further interference. Relief by this method is immediate. The operation was suggested by a case of Mr. Critchett, where the division was made for relief in ophthalmia neonatorum. This division of the tarsus has the advantage of freedom from all resulting deformity of the lid.—*Am. Jour. Ophth.*, Aug., 1889.

MEDICINE AND PATHOLOGY.

Scott (A. T.) on a Gummatous Growth Simulating Rupture of a Muscle.—During April I was consulted by J. B., aged fifty-five, concerning a growth which, he stated, had suddenly made its appearance in the right hypochondriac region. On examination I found in the situation of the right rectus abdominis a fulness about two inches square. The upper border was well defined and sharp, and the hand could be introduced above it, whilst the lower extremity was less distinct, fading into the general substance of the rectus. The patient was positive that the fulness had arisen suddenly, and added that he had been lifting heavy weights lately. The history and general characters of the growth pointed to a rupture of the rectus muscle, but the symmetry and unimpeded facility with which the abdominal parietes could be contracted rendered this highly improbable. On careful questioning I elicited the fact that he had formerly served in the army, and whilst in India, about sixteen years ago, had contracted a sore on the penis. With the characteristic indifference of his class, he did not appear to have observed any constitutional symptoms, but his wife, to whom he was married shortly after his return from abroad, had had a succession of miscarriages and one dead child. On this I decided to place him on iodide of potassium, and after a week's treatment with full doses the growth had sensibly diminished, although the upper border was still as defined as ever. The after-progress of the case presented nothing unusual, and the steady decrease of the growth under the iodide proved it to have been a gumma occupying one of the quadrilateral segments of the rectus.—*Br. Med. Jour.*, Oct. 12, 1889.

Davis (W.) an Open Safety-Pin Swallowed by an Infant of Eight Months; Passed per Anum after Thirty-Seven Days.—I think the following case worthy to be put on record, to

show what awkwardly-shaped substances will pass through the alimentary canal in safety, and also to act as a consolation to the parents of any other child who may meet with a similar accident:

On August 27th last I was called to see an infant of eight months said to be choking. I could discover nothing in the throat and the child could swallow water, but the mother said it had had an attack of choking and gagging a little before and she had felt something hard in the back of its mouth. As a safety-pin was missing from its bedding she felt sure the child had swallowed the pin. A careful search was made for this pin, but it was not found. Two days after, the father told me that the child had passed several pieces of worsted, and the previous attack of choking seemed to be explained.

On Oct. 3d the mother discovered something protruding from the anus, and with some difficulty extracted the missing safety-pin, which was spread wide open. It measured an inch and an eighth in length and spread nearly an inch. It was a plain brass pin and had become but slightly corroded. As these pins are held open by a stiff spring, it is something of a mystery how it could have groped its way through the narrow intestinal canal of a child without sticking fast somewhere.—*Northwestern Lancet*, Oct. 15, 1889.

The Cerebral Complications of Ear Disease.—Dr. Otto Körner of Frankfort points out that all the cerebral complications of ear disease are more frequent on the right than the left side. Thus, of 31 cases of cerebral abscess, 18 occurred on the right side from disease of the right ear, and 12 on the left from disease of the left ear, and in one case there was abscess on both sides following disease of both ears. Similarly, of 61 cases of thrombosis of the lateral sinus, 35 were met with on the right side and 26 on the left. Of 23 cases of meningitis from ear disease, 17 affected the right side and 6 the left. Adding these together, we have a total of 115 cases, of which 70 were on the right side, 44 on the left side, and 1 bilateral. Körner traces this greater frequency on the right side to the fact that the groove for the lateral sinus passes further forwards and outwards into the petrous and mastoid bones on the right than on the left side. The bony wall separating the sinus from the mastoid antrum is therefore thinner on the right side. Added to this is the fact that in brachycephalic skulls the anterior cerebral fossa is considerably nearer the mastoid antrum than in the dolichocephalic. In the former cerebral complications of ear disease more readily ensue than in the latter.—*Lancet*, Sept. 14, 1889.

The Vision Area in the Encephalon.—In a note on the seat in the encephalon of the chromatic sense, of the luminous sense, and of the sense of forms, Dr. Vaney, after several observations, arrives at the following conclusions: that the chromatic sense resides in the lowest portion of the occipital lobe, probably in the posterior part of the lingual and fusiform gyri; the luminous sense would be found higher, near the upper part of the occipital lobe, and the centre of perception of forms between the two preceding regions. The author had an opportunity of verifying his conclusions in the following case that came under his observation. A woman aged sixty years was seized with cerebral congestion, without loss of consciousness, and accompanied with vomiting. There was a distinct hemiachromatopsia, with partial preservation of the light perception and form. There were no aphasic troubles, no word blindness, no paresis or paralysis of the extremities. The ophthalmoscope revealed no lesion whatever of the optic nerve. This state remained stationary for twenty months. In March, 1888, the patient succumbed in a few days to an attack of apoplexy, which produced a hemiplegia of the left side. At the autopsy an enormous hemorrhagic focus, of recent formation, was found in the right cerebral hemisphere; the lesion had destroyed the whole of the centrum ovale, the central ganglia, and had penetrated into the right lateral ventricle. There existed a very old lesion, a hemorrhagic cyst, at the inferior portion of the left occipital lobe.—*Lancet*, Oct. 12, 1889.

Peterson (F.) on Electrical Injuries.—The author does not believe any new or unknown disease had been introduced by the employment of dangerous electrical currents in various industries, for precisely the same disorders have been known to the profession as occurring from electricity in its natural form of lightning. Lightning produces shock of all degrees to the nervous system. As one third of the people struck escape death, it is from disorders of the nervous system that these victims suf-

fer, and these diseases are commonly functional in character. Among the most frequent neuroses, generally of a transient character, produced by lightning, are catalepsy, aphonia, deafness, blindness, tinnitis aurium, neuralgias, iridoplegia, and various paralyses and anæsthesias. One instance was that of an intermittent brachial monoplegia recurring at every storm. He cites experiments with artificial lightning—discharges from Leyden jars—made upon lower animals by Richardson twenty years ago, and by Nothnagel nine years ago, in which varying degrees of anæsthesia and paralysis were produced, transitory in nature.

As to the pathology of electrothanasia, he had made autopsies upon a number of dogs at the Edison laboratory, after killing them with dynamo currents, and examined many tissues microscopically immediately after death, and some later, after hardening in Müller's fluid. In all the blood was dark and thin. Electricity has been shown experimentally to rob the blood of its oxygen; a shock sent through a test-tube of blood will darken it, while shaking in a jar of oxygen restores the redness. The blood and all the visceral tissues seemed normal under high magnification. He had examined microscopically lung, muscle, nerves, spinal cord, brain, etc., but found no changes. In two dogs there were capillary ectasies in the sheaths of the large leg-nerves through which the current had passed, and also in the spinal cord, with here and there extravasations of blood. The action of the current is probably both chemical and mechanical. Its mechanical force is expansive or explosive in its nature, thus accounting for the coarse lesions found often after death by lightning—perforation, amputation, etc. The following case was a good example of the sort of neurosis produced by a shock from a commercial current:

An Elevated Railroad employee, aged twenty-five, hitherto a very strong and healthy man, on August 13, 1889, about 11 A.M., while at work picked up a wire on the Elevated Railroad, which was probably dead, but enlivened by his moving it and bringing it into circuit with some other. He had a buzzing in his head, and instant muscular rigidity followed almost immediately by relaxation. He had evidently made a circuit by picking up the wire, and his tetanic spasm had broken it again. He felt momentarily unhurt, then fell in a heap, and was conveyed to hospital. In the ambulance he recovered consciousness, but was so drowsy at the hospital that they forcibly kept him awake. He was burned but very slightly. He was able to walk home unassisted at 6 P.M. the same day. For a week he had considerable muscular twitching, like chorea; suffered from insomnia, and when asleep would dream of touching the wire, getting a shock, and would then suddenly waken. There is no sign now of any organic disease about him. He is unable to work, however. He has pain in moving his eyes, but his eyes are normal. He walks in a stooping position, and says he cannot straighten up because of pain in his back. His muscles twitch occasionally, according to his account, and he has a slight tremor, and the knee-jerks and wrist-jerks are exaggerated. He is troubled with headache, and his face has a somewhat anxious look. He evidently has sustained a profound shock to his nervous system, and his mind is much absorbed in the contemplation of his morbid condition and symptoms. His state is more than one of neurasthenia, and less than hypochondriasis. It evidently corresponds to the traumatic neuroses due to other kinds of shock, like railway-brain, railway-spine, etc.

He mentioned another case of a man in whom choreiform movements had developed after a severe shock from an electric-light wire.—*Medical Record*, Nov. 2, 1889.

Complications of Gonorrhœal Rheumatism.—Bornemann of Copenhagen has recently described the various forms of complication which are met with during an attack of gonorrhœa, of which the symptoms are analogous to those attributable to rheumatism. The most common seat of so-called gonorrhœal rheumatism is that of articulations; then follow the tendons, the lastly periosteum, nerves, muscles, eyes, and the pleura. The author's observations were based upon 278 cases of patients suffering from gonorrhœa, who came under treatment in the wards of the hospital at Copenhagen. In these patients the knee was affected 240 times, the foot 151, the shoulder 68, the metacarpo-phalangeal joints 52, the other articulations of the hands 51, the hip 46, the elbow 45, the jaw 12. The presence of increased amount of fluid in the synovial sacs was frequent but not constant; for example in the 240 in-

stances in which the knee was affected, the excess of fluid was noted in 183 times. Affections of the tendons and synovial bursæ occurred in 41 patients: four other patients suffered from periostitis; while there were three cases in which muscles were attacked. Out of this number of 278 patients the author met with two cases of endocarditis, gonorrhœal ophthalmia was comparatively frequent, having developed in 45 instances, and sciatica occurred five times. With reference to the question of the discovery of the gonococcus in the synovial fluid of a joint attacked with gonorrhœal rheumatism, confirmation of the statement is still wanting. The author has found several times in the synovial fluid of the knee after puncture, micro-organisms which do not comport themselves like gonococci. He believes them to be identical with the cocci found in the tissues invaded by suppurative processes. —*Med. Press*, Oct. 23, 1889.

Duvall (W. A.) on a Case Showing the Contagiousness of Phthisis.—A man of thirty-four had been sick with phthisis about four years; gradually grew from bad to worse, until the usual end was reached. It was not until the last three or four months of his life that he was confined to his bed. He was fond of pets, and during these three or four months, it was his fancy to have his dog in the room nearly all the time.

The animal would jump on the bed with his master, and there often slept, near the mouth that was giving out the poisoned air, thus breathing that which should be most avoided. It was not long before the dog began to show signs of starvation, noticeable even to the sick man. The pet's food was looked after, but no change in the condition. Gradually the animal grew worse, and in less than a month after the master's death, the faithful canine had to succumb to the waste and cough.—*Maryland Med. Jour.*, Nov. 2, 1889.

Clark (A.) on the Non-Tubercular and Non-Cardiac Hæmoptysis of Elderly Persons.—The author thinks that there occurs in elderly persons, free from ordinary diseases of the heart and lungs, a form of hæmoptysis arising out of minute structural alterations in the terminal blood-vessels of the lung.

These vascular alterations occur in persons of the arthritic diathesis, resemble the vascular alterations found in osteo-arthritic articulations, and are themselves of an arthritic nature.

Although a sometimes leading to a fatal issue, this variety of hæmoptysis usually subsides without the supervention of any coarse anatomical lesion of either the heart or the lungs.

When present this variety of hæmorrhage is aggravated or maintained by the frequent administration of large doses of strong astringents, and by an unrestricted indulgence in liquids to allay the thirst which the astringents create.

The treatment which appears at present to be the most successful in this variety of hæmoptysis consists in diet and quiet, in the restricted use of liquids, and the stilling of cough; in calomel and salines, in the use of alkalies, with iodide of potassium, and in frequently renewed counter-irritation.—*Lancet*, Oct. 26, 1889.

Immunity Produced by an Albumose Isolated from Anthrax Cultures.—In 1887, Messrs. Salmon and Smith showed that if a culture of the bacillus of hog-cholera, after being sterilized by heat (58° C.), was injected into an animal, the latter acquired an artificial immunity against the bacillus of hog-cholera, so that when the living micro-organisms were injected they produced no symptoms. The demonstration of chemical vaccinating substances was not altogether satisfactory until Charrin, in the same year, proved that the introduction of a heated and filtered culture of the bacillus pyocyaneus protected rabbits against the inoculation of the living bacillus pyocyaneus. Roux and Chamberland shortly afterwards proved this to be true for malignant œdema, whilst Chantemesse and Vidal were able, by using a similar method, to protect mice against the evil effects of the typhoid bacillus. The experiments of Dr. Wooldridge on anthrax are also of the greatest importance, as showing the protective power of chemical substances.

The latest contribution to our knowledge of immunity is the paper by Mr. E. H. Hankin, who claims to have prepared from the cultures of anthrax an albumose which, when injected into mice or rabbits, protects these animals against the action of the anthrax bacillus. Mr. Hankin's experiments were made under the guidance of Professor Koch, at Berlin, and, as far as they go, appear to warrant us in thinking

that he has discovered an improved method of vaccinating against anthrax.—*Br. Med. Four.*, Oct. 12, 1889.

Inoculation against Inflammation of the Lungs in Cattle.—At the end of last year the Prussian Minister of Agriculture ordered experiments to be made on cattle, in order to decide the extremely important question whether inoculation affords protection against infectious inflammation of the lungs in cattle or not. These experiments were carried out under the superintendence of Professor Schütz and the departmental veterinary surgeon Steffen, in the government district of Magdeburg, and have recently been finished. On Oct. 8th last twelve young bulls were inoculated with fluid and particles from diseased lungs; three with warm and three with cold fluid; three with warm and three with cold particles. Those inoculated with warm fluid contracted the disease most severely. On Oct. 26th all twelve, along with four uninoculated animals of the same age and breed, were placed among cattle suffering from infectious inflammation of the lungs, and their noses were repeatedly brought into the closest contact with those of the diseased animals for hours together. In December and in January all the animals were killed, and the post-mortem showed that the twelve inoculated animals had remained healthy, and that three of the four uninoculated ones had contracted the disease. The experiments were now repeated, special care being taken that all the animals (inoculated and uninoculated) were exposed to as nearly as possible equal degrees of infection, and that the fluid used for inoculation was taken warm from the lungs which had proved most effective. On Nov. 9th twelve young bulls were inoculated with different quantities (0.05 to 1.0 cubic centimetre) of warm lymph. The quantity of the fluid used did not affect the intensity of the local process. One bull died on the thirty-fifth day after inoculation of peritonitis, caused by the spread of the inoculation process. On Dec. 1st the inoculated bulls were placed among bulls suffering from infectious inflammation of the lungs, but did not contract the disease. On Jan. 27th they were taken to another stall, and again placed among bulls suffering from the disease in question. On April 12th the eleven inoculated and two uninoculated bulls were inoculated with warm lymph between the neck and the breast, after which the two latter became severely ill, and one of them died. The previously inoculated animals, on the other hand, showed only slight symptoms at the place of inoculation. On April 12th twenty grammes of warm lymph were mixed with 2,000 of warm sterilized flesh broth and sprayed before the nostrils of the inoculated animals. They remained healthy. On May 13th they were again placed among others which were suffering severely from the disease in question. After this no morbid symptoms were observed in them. On June 26th one cubic centimetre of warm lymph was injected into the lungs of each of the inoculated and of two uninoculated bulls. The inoculated animals remained healthy, while the two uninoculated ones contracted the disease in a very severe form, and one of them died. At the end of July the inoculated animals were killed and dissected, and no abnormal developments were found. It therefore now seems to be proved that cattle inoculated with fresh warm lymph are protected against infectious inflammation of the lungs.—*Lancet*, Oct. 19, 1889.

THERAPEUTICS.

Fussell (M. H.) on Quinine in Labor.—The drug was always administered in doses of fifteen grains.

Of the twenty-seven cases reported, twenty-two had previously borne children; five were primiparæ. Twenty of the twenty-two cases were in labor at the time of administration; two had "false" pains. In sixteen of the twenty cases the pains were markedly increased, and labor speedily terminated. In five cases, the dose, fifteen grains, was repeated generally two hours after the first dose, with effect of at once bringing on strong pains. If the dose had been repeated in two other cases it is fair to suppose that a like result would have followed in them. These two cases are of especial value in the series, showing that a single large dose does not necessarily precipitate labor even at term.

The drug was administered to five primiparæ. In but one of the cases was it of any value, even though it was repeated. I have not seen this peculiarity noticed by any of the writers, but the fact remains that in all the cases in which I have ad-

ministered quinine to primiparæ, only one case was in any way favorably affected by it. I am unable to give any reason; the os was well dilated, and the women had been in labor a number of hours. It has become a practice with me since my experience to abstain from administering quinine to a primipara.

Two cases were within a few weeks of term; both thought they were in labor, and in neither did the fifteen grains of quinine have any effect save to cause cinchonism. So far as this goes they are in accordance with the greater mass of testimony that quinine is not able to originate labor save at term. There was but little cinchonism except in two cases.

The conclusions to be drawn are:

First. That in multiparæ where labor is delayed on account of uterine inertia, quinine in fifteen-grain doses will hasten it.

Second. That in primiparæ the drug is of much more uncertain value.

Third. That large doses may not originate labor before term.—*University Med. Mag.*, October, 1889.

Easby (W.) on a Case of Dysentery Treated by Injections of Sulphate of Copper.—A thin, spare man, aged fifty, lived in the Cambridgeshire Fens, and in his young days had suffered from ague. The water-supply to his house was very bad; the usual drinking water was rain water kept in a wooden tub, and when this ran short that from the dykes was used. I first saw him on December 31, 1876; he had all the symptoms of a smart attack of dysentery; these continued for a week, when he was much better. On January 14, 1877, he had a relapse, but improved by the 20th. On the 21st I heard he was worse, and was passing a lot of blood, and had much tenesmus. I at once prepared an injection of sulphate of copper, 10 gr.; tincture of opium, 1 dr.; and 4 oz. of water. On reaching the house I found him lying in a small pool of blood. He informed me this had been going on all night, and the tenesmus was unbearable, bringing away blood and mucus. I well oiled a large long gum-elastic catheter, and with a finger in the rectum passed it as far into the bowel as it would go, which was at least fifteen inches; through this the copper solution was injected from a small brass syringe; it caused no pain; and in the evening the tenesmus was relieved, and very little blood had passed. On the 22d he was decidedly better, but more blood in the stools than I liked, so the injection was repeated, and again on the 23d; and from this date he recovered rapidly. My treatment prior to the copper injection was bismuth, gallic acid, a full dose of powdered ipecacuanha; but nothing gave such rapid and permanent relief as the copper and opium. The diet was purely milk. I have not had such a bad case as this in an adult since, but in children several; and here the same treatment proved successful.—*Lancet*, Oct. 12, 1889.

Sympson (E. M.) on Glycerine of Borax in the Diarrhœa of Infants.—If we regard infantile diarrhœa as due to the excessive fermentation of food in the intestinal canal causing irritation and a catarrhal condition of the intestinal mucous membrane, it seems reasonable to look for a remedy to act both on the cause and effect. Glycerine itself is an antiseptic of no mean order, and relieves the congestion and pain of inflamed piles, chiefly mucous surfaces, while every mother knows the virtues of glycerine of borax when applied to the mucous membrane of the mouth. So it was no great step to introduce it further into the alimentary canal. Whether fed from the breast or brought up by hand, the motions of patients with diarrhœa infantum were like curds of milk, suggesting that the irritated intestine had hurried its contents on as quickly as possible. Again, they were very foul-smelling, suggesting great fermentation. Therefore the glycerine of borax has to do two things; to act as an antiseptic to prevent excess of fermentation in the stomach and intestines, and to soothe the mucous membrane thereof in passing over it. I have found it answer capitally; the children like it, it lessens the griping pains, it renders sweet the offensive motions, and it stops the diarrhœa. One case died while under this treatment; the child was seven months old, had had diarrhœa two days, and was utterly worn out when I saw it. But I suppose there always will be cases which come under our notice too late for cure. I give it as follows: Glycerine of borax, twenty minims; tincture of orange, three minims; distilled water to one drachm. To be given every one, two, or three hours, according to the severity of the case or the age of the patient.—*Lancet*, Oct. 12, 1889.

Hewitt (F.) on the Various Points to be Considered in the Selection of an Anæsthetic.—

(I.) Length of anæsthesia required.	(II.) Anæsthetic to be Employed unless Contra-indicated.	(III.) Examples of Suitable Cases.	(IV.) Contra-Indications to Anæsthetic Mentioned in (II.): (a) By Reason of Nature of Operation.	(IV.) Contra-Indications to Anæsthetic Mentioned in (II.): (b) By Reason of Morbid or Other Condition of Patient.
30 seconds or less.	Nitrous oxide.	Tooth extraction; opening an abscess; incising a whitlow.	1. Operations requiring perfect quietude and total muscular relaxation.[1] (Nitrous oxide with a small quantity of ether should be employed in these cases.)	1. Children under three years. (A. C. E. mixture best anæsthetic.)
30 to 60 seconds.	Nitrous oxide and air alternately.	Slitting up a sinus; avulsion of toe-nail; temporary application of actual cautery.	1. Operations requiring perfect quietude and total muscular relaxation.[1] 2. Nasal or oral operations with hemorrhage. (Nitrous oxide with a small quantity of ether should be employed in these cases.)	2. Patients suffering from pulmonary, pleural, or other conditions attended by embarrassed breathing. (A. C. E. mixture or chloroform diluted with alcohol should be employed.)
	Nitrous oxide with a small quantity of ether.	Rectal, vaginal, or urethral operations[1]; breaking down adhesions of joints; certain dental operations; post-nasal adenoids.[2]	1. All operations within the upper air-passages with actual cautery. (Chloroform, chloroform diluted with alcohol, or nitrous oxide administered intermittently with air, must be employed in these cases.)	3. Extreme asthenia; collapse. (Pure ethylic ether sparingly administered from a cone or towel should be given in such cases.)
Over 60 seconds.	Nitrous oxide followed by a quantity of ether proportionate to length of operation.	Ordinary surgical cases.	1. All operations within the upper air-passages with actual cautery. 2. Operations in mouth or nose of too long duration to be performed after a full dose of ether,[4] for example, cleft palate, long cases of epithelioma of tongue or floor of mouth, etc. 3. Operations in which venous engorgement would constitute a serious difficulty or danger, for example, removal of glands at root of neck, tracheotomy, operations upon the brain or its membranes, etc. 4. [Abdominal surgery.[5]] (Chloroform, or chloroform diluted with alcohol should be used in above cases.) 5. Removal of tonsils. (A. C. E. mixture best anæsthetic, as a general rule.)	1. Children under three or four years. 2. Old people.[3] 3. Extremely fat subjects, 4. Persons suffering from affections of the air-passages or pleuræ, with but slight embarrassment to respiration. 5. Morbus cordis, with feeble or irregular cardiac action (including fatty degeneration of the heart.) 6. Extreme abdominal distension. 7. Cases highly intolerant of ether. (A. C. E best anæsthetic in above cases.) 8. Extreme asthenia; collapse; for example, neglected strangulated hernia. (Pure ethylic ether sparingly administered from a cone or towel best anæsthetic.) 9. All conditions causing such narrowing of the upper air-passages as to produce temporary or abiding difficulty in breathing, for example, tumors of the soft palate, aneurism pressing upon the trachea, laryngeal diseases, etc. 10. Affections of lungs or pleura attended by dyspnœa or cyanosis,—for example, advanced phthisis, empyema, pulmonary œdema in the course of morbus cordis. 11. Marked atheroma. 12. Advanced renal disease. (Chloroform, preferably diluted with alcohol, best anæsthetic in these cases.)

[1] Although nitrous oxide narcosis may be unattended by reflex movement, jactitation, and rigidity, these phenomena are liable to manifest themselves, more especially in strongly built men, highly nervous and hysterical subjects, alcoholics, habitual smokers, children, and those undergoing operations upon the genito-urinary passages.

[2] Mr. Braine's plan is the most satisfactory. He places the patient under ether (preceded by nitrous oxide), raises him to the sitting position with the head bent forward, and, having opened the mouth with a gag, permits the operator to have free access to the naso-pharynx. The blood and dislodged adenoid growth escape through the nose and mouth, and respiration is not interfered with.

[3] Generally speaking ether should not be administered to patients above 60 or 65 years of age; but if a brief operation has to be performed upon such a patient, and the latter is not markedly atheromatous or emphysematous, ether preceded by nitrous oxide may be safely employed.

[4] In many of these cases it is possible and desirable to give gas and ether to deep etherization, and to leave the operator plenty of time for the operation; and in the event of the anæsthesia thus produced being insufficient, chloroform or chloroform diluted with alcohol may be subsequently administered through the mouth or nose by means of the tube of Junker's inhaler.

[5] In abdominal surgery chloroform possesses many advantages over ether, but considering the greater risk which attends the administration of the former agent, it is questionable whether these advantages should be allowed to influence the administrator in the choice of the anæsthetic. Respiration is much quieter under chloroform than under ether; the engorgement of the parts is considerably less than when the latter anæsthetic is used; and the tendency of the patient when emerging from the anæsthetic state to cough and strain is certainly less after chloroform than after ether. Opinions vary with regard to the relative frequency of vomiting after these anæsthetics; but it seems tolerably certain that, whilst chloroform and the A. C. E. mixture are less frequently followed by vomiting than ether, *obstinate* vomiting is most common in those cases in which chloroform has been employed. In conclusion it may be affirmed that, so far as the actual performance of the operation is concerned, chloroform possesses advantages over ether, but that the risk to the patient upon the operating table is certainly greater under the former than under the latter anæsthetic.

Note on the Administration of Anæsthetics during Labor, Presence of Renal Disease.—In these cases the A. C. E. mixture or chloroform (preferably diluted with alcohol) should be employed, and need only be administered till the [illegible]

Dodd (P. V.) on a Case of Phosphorus Poisoning.—On Wednesday, August 4, 1889, a servant girl, aged nineteen, was brought into the workhouse, Devizes, in a semi-conscious state, after having been dragged out of the canal, into which she had thrown herself in an attempt to commit suicide by drowning. She recovered consciousness after artificial respiration had been resorted to, but was in a very weak condition. On the following day she was a good deal better, and on Friday there seemed no reason why she should not recover. On Saturday nothing particular was noticed about her except her complaining of slight pain in the epigastrium. On Sunday, the fifth day after having been brought in, I found her with very marked jaundice, and she complained of slight pain in the epigastrium and intense thirst. There had been no vomiting and no diarrhœa. There was no evidence nor history of her having taken any poison. On Sunday night she was worse and in a state of collapse, and on Monday morning she died, after suddenly vomiting a quantity of blood. This occurred on the seventh day after taking phosphorus, as it was afterwards discovered. This sudden vomiting of blood was the first and only time vomiting had occurred during the illness.

On Tuesday a post-mortem examination was made, with the following result: The whole body was marked by jaundice, and the finger-nails very blue. The heart was of a yellowish color, and the chambers were empty. The aortic valves and internal coat of the aorta were of a dark, uniformly pink color, which extended halfway down the abdominal aorta. The discoloration was very noticeable, showing how rapidly decomposition takes place in phosphorus poisoning. In the substance of the lungs were small hemorrhages, as also on the surface of the pleura. The stomach was distended with dark coffee-colored blood; the lower part of the internal surface was plum-colored, this discoloration fading off towards the duodenal end, where the color was normal. The first three feet of the small intestine also presented a deep plum-color on its inner surface, getting paler below. The œsophageal end of the stomach and the œsophagus were normal. The mucous membrane of the stomach was soft and giving way under the finger. There was no perforation. The liver had hemorrhagic spots on the surface, and was very pale on section, soft, and fatty. The gall-bladder was empty. The kidneys were bile-stained, and there were small clots of blood in the pelvis.

There was no reason to suspect her having taken poison during life; this fact was only brought to light by the post-mortem examination, and eventually proved by a packet of phosphorus paste three parts empty being found in her box.

This is another of those cases of phosphorus poisoning in which the symptoms do not show themselves till at least a week after taking the poison, and then set in rapidly. She evidently threw herself into the canal when she found the poison was not taking effect.—*Brit. Med. Jour.*, Oct. 19, 1889.

Leloir on Mercurial Injections.—The author has used for hypodermic injections in syphilis, calomel, yellow oxide of mercury, and gray oil. The injections were of most service in the secondary cutaneous symptoms, but of little or no use in mucous patches or tertiary lesions. The most important evil effects observed were: local pain, sometimes lasting over a week; paresis of the lower extremities, headache, vertigo, mercurialism, and a painful non-suppurating tumor at the site of the injection. Mucous patches have been observed, occurring several days after an injection. The injections should never be used in cases of spinal or cerebral syphilis. Relapses are common after treatment by injections.—*Med. Record*, Sept. 14, 1889. C. W. C.

Renault (A.) on Senile Syphilis.—Syphilitic manifestations in old age, on account of the general weakening of the whole system, are a very much more serious matter than in early manhood. The chancre has at first the same appearance as that in persons of any age, but has a remarkable tendency to ulceration, which may lead to an erroneous diagnosis of epithelioma. Cicatrization is very slow. Adenitis is slow in appearing, often not until the sixth or seventh week. The syphilitic fever is so marked that it may be mistaken for typhoid or malarial. The syphilides are distinguished by their tendency to become confluent, their obstinacy and resistance to ordinary therapeutic measures, by frequency of relapses, and their proneness to assume tertiary forms. Cutaneous gummata make their appearance early. The nervous system is especially affected, and

disorders of sensation, motion, and special senses are frequently met with. Marked cachexia and profound anæmia may be regarded as characteristic symptoms of the secondary stage of senile syphilis. The tertiary lesions are unusually severe, and the cutaneous manifestations are characterized by their general diffusion over the body and difficulty to cure.—*Med. Record*, Sept. 29, 1889. C. W. C.

Watkins (T. J.) on a Concentrated Solution of Magnesia Sulphate as an Enema, etc.—The advantages of this enema are :

1. Its action is local, producing diffusion.
2. Its action is free and seldom fails.
3. Time of action is short.
4. The bulk is small, causing but very little, if any, discomfort.
5. It is as unirritating as a simple enema. Its certainty of action has become so well recognized in the New York Woman's Hospital that it has been used in nearly all the operative cases, as the cathartic preparatory to operation, for the last six months.

It is best administered with the patient in Sim's position, the hips being elevated by a pillow ; and when much tenderness exists it is best given through a large gum-elastic catheter passed well up into the bowel. The patient is to be instructed to allow the abdominal muscles to remain lax, and the nurse is to keep up pressure over the anus, if necessary, to cause it to be retained for at least fifteen or twenty minutes. If the bowel should fail to expel the exuded liquid, a rectal tube had better be inserted in order to allow it to escape. It has not produced any bad results when two ounces have been retained, but Christison reports a case of death in a boy ten years old where two ounces were taken by the mouth without causing any purging. In my cases it probably was excreted by the kidneys nearly as fast as it became absorbed. Where it is retained the sphincter ani is likely to be strongly contracted, and great relief will follow paralysis of the sphincter by forcible dilatation under an anæsthetic, which will also have a good effect over the chronic constipation usually present.

The following is the formula I use :

℞	Magnesii sulph.	2 oz.
	Glycerinæ	1 oz.
	Aquæ . . . . . q. s. ad.	4 oz.

The solution is made more readily and its power of diffusion increased by the addition of glycerine. I have used three or four ounces of the salt, but do not see that it has any advantages over the smaller amount.—*Maryland Med. Jour.*, Nov. 9, 1889.

BOOK NOTICES.

Essentials of Physiology.—By H. A. Hare, B. Sc., M. D. (Univ. of Pa.).

The author, who is Instructor in Physiology in the Biological Department of the University of Pennsylvania, has compiled from the standard works of Landois, Yeo, Foster, Dalton, Baker, Herman, and Chapman, an excellent question-compend in Physiology. The form of question and answer is helpful, the plates excellent, and the selection of the subject-matter is well-advised. To the student who feels that he must have a condensation of the subject of Physiology, this little book will prove a valuable aid. E. S. B.

A Clinical Atlas of Venereal and Skin Diseases Including Diagnosis, Prognosis, and Treatment.—By Robert W. Taylor, A. M., M. D., Surgeon to Charity Hospital, etc.

Part VII., Diseases of the Skin.

The first article is on scabies and is well illustrated by wood-cuts and chromo-lithographs.

There follow chapters on dysidrosis, miliaria crystallina, impetigo contagiosa, and eczema impetiginodes from lice.

A chapter is devoted to eruptions of iodic origin, which are classified under the heads of erythema, papular and papulo-pustular dermatitis, urticaria, bullous eruption, dermatitis tuberosa, subcutaneous nodular tumors and a petechial form of iodic intoxication. The only iodic eruption delineated in color is the bullous or pemphigus-like eruption.

The plate depicting the bromide of potassium eruption, taken from the New Sydenham collection, rather poorly portrays the lesion intended, but that may be the fault of the copying artist. The elevation of the edge of the lesion seems too great and the excavation of the centre too deep. The appearance of the dried secretion is natural and the bluish-red hyperæmia about the lesions is very correctly shown.

The remainder of Part VII. is devoted to sycosis, molluscum sebaceum, ichthyosis, and leprosy.

Part VIII. deals with lichen planus, lichen ruber, lupus vulgaris, molluscum fibrosum, scleroderma, acne rosacea, rhinosclerma, elephantiasis, leucoderma, chloasma, alopecia areata, keloid, and xeroderma pigmentosum.

Part VIII. concludes the work, which is closed by a full gereral index, *a preface*, table of contents, list of colored plates and their sources, and list of wood-cuts and their sources.

In every respect the present parts correspond in excellence with previous ones. The entire work being an invaluable reference and text-book.

R. W. A.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

VOL. VI., No. 47. November 21, 1889. WHOLE No. 147.

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NEPHRORRAPHY.

In the *Lancet* for Oct. 6, 1888, the following case is reported by Mr. Gould :—S. S., aged 28, married, mother of four children, was admitted into the Middlesex Hospital on July 2, 1888. She had enjoyed good health all her life until three months before, when she was suddenly seized with intense pain in the right loin, shooting down into the right groin and across the abdomen. These attacks, varying in severity, had been repeated ever since, and she had not had more than one week's immunity from pain. The pain was always increased by exertion and subsided when she rested. Micturition during the attacks of pain had been frequent and painful, but she had not noticed any change in the urine. The bowels had been very confined. On admission, the patient was found to be a fairly nourished woman ; but the abdominal walls were notably lax. A freely movable tumor was easily felt in the right lumbar region, with a rounded outline except at the upper and inner edges where a notch could be felt in it. The surface was smooth. During deep inspiration the tumor was found to descend into the iliac fossa, but during inspiration it was easily pressed back, and up into the loin and under the ribs. When she turned on her left side the tumor fell forward, and could be easily grasped between the two hands—and when compressed, pain of a sickening character, like that experienced during the attacks of pain, was felt. The left kidney is felt in the normal position, and not unduly movable. Urine :—sp. gr. 1015 ; acid ; no albumen. A movable kidney was diagnosticated, and the operation of nephrorraphy was recommended.

On July 10th the patient having been anæsthetized, was placed on her left side, and an incision about four inches long was made in her right loin, parallel with and two inches below the last rib. The muscles and the lumbar aponeurosis were divided and the fat around the kidney was pricked through with forceps, and the kidney exposed, and pushed well up into the wound by an assistant. A large curved needle, armed with Kangaroo tendon was passed through the kidney so as to take up a broad portion of its capsule and cortex. Each end of this suture was then separately passed through the contiguous cut edge of the lumbar aponeurosis. A second suture was passed in the same way, and then both were tied, the assistant fixing the kidney in the wound all the time. The wound was then well irrigated with corrosive sublimate solution (1 : 2,000), closed with deep and superficial sutures, a drainage-tube inserted, and dressed with alembroth wool, kept in place by strapping. The wound was dressed for the first time on July 13th ; there was then a very slight serous discharge, but no redness and no pain. The tube was removed on July 16th and the sutures on the 20th. She got up on July 26th and left the hospital on Aug. 1st with the wound firmly healed and the kidney fixed in the loin. She bore the journey to Portland well, and when last

heard of at the end of September, had had no return of her old troubles.

The doubts that were for a long time entertained as to the nature of the conditions called "floating kidney" and "movable kidney" seem to be paralleled by those held as to the best form of treatment. When Hahn's operation was first published it was hoped that an easy and safe means of permanently curing the undue mobility of the kidney had been discovered. But it was not long before reports of the failure of the operation were heard, and it is not uncommon now to hear surgeons speak of nephrorraphy with very little confidence. It is easy to understand that the fixation of the kidney secured immediately after the operation may gradually be lost as the cicatricial tissue is absorbed and stretched, and it is therefore necessary not to trust to this measure of fixing the kidney, but to fasten it in its place by sutures which will permanently hold it. This was forcibly impressed upon me by the first case in which I was called upon to do this operation. The patient was under Dr. Coupland's care in the Middlesex Hospital, with very painful symptoms, due as we thought to the mobility of the right kidney. At the operation I had the able assistance of Mr. Henry Morris. A silk suture was passed through the whole thickness of the lumbar incision, then through the kidney, and out again through the thick tissues of the loin. This suture had to be removed in a few days. The patient made an excellent recovery, and at first all was satisfactory, her symptoms being entirely removed. But in three months she returned as bad as ever, and I found that the kidney had become as loose as before. I ought to add that she had worn a well-fitting abdominal belt ever since the operation. I then determined to operate again and fasten the kidney to the lumbar aponeurosis with Kangaroo tendon which should be allowed to remain permanently *in situ*. This succeeded well and she has had no return of her old symptoms, nor can the kidney be felt to move. I have met with the same results in another case.

The mode of passing the suture is, I think, of importance. If a large curved needle, such as is often employed, is made to carry the suture at a single sweep, the surgeon is very liable to tear through the kidney, and even to some extent its capsule. I prefer first to pass the suture through the kidney, taking up as broad a piece of its capsule and cortex as I can, and then to pass each end of the suture through its corresponding portion of the lumbar aponeurosis. Two sutures passed in this manner are sufficient to hold the kidney firmly, and if they are tied carefully, the chance of their cutting out through the kidney, and so not holding it so securely as desired, is reduced to a minimum. A subsidiary advantage of this buried suture is, that the wound can be closed smoothly and accurately by the ordinary sutures. When the kidney is fixed by external sutures, they pucker the wound, and interfere with the most rapid and perfect healing. As to the material of the deep suture, there is room for divergence of opinion and practice. Silk, as being more durable than gut or tendon, would be preferable, were it not that it is more difficult to render absolutely aseptic than is Kangaroo tendon. At any rate that has been my experience, and the tendon has answered so well in my hands as a ligature in ovariotomy, and as a suture in the radical cure of hernia, and up to the present in nephrorraphy, that I use it with full confidence.

Dr. L. H. Dunning, *West. Med. Rep.*, Oct., 1888, reports the following cases: Case I.—Mrs. A., aged 54, operated upon Oct. 30, 1884. Nephrorraphy was done in the ordinary way by lumbar incision. The cellulo-adipose tissue surrounding the kidney was stitched into the edges of the wound. Two deep sutures of catgut untied in 24 hours, and partly pulled out. The operation was but a partial success, as the organ was found to have a range of motion of one inch in a nearly transverse direction after the patient left the bed. She was relieved of vomiting for a while and of the dragging pains, but at the end of one year they had returned, and her suffering had become as intense as formerly. The kidney was extirpated, and the patient lived with greatly improved health, but was not relieved of vomiting. Case II.—Miss B., colored, single, under observation several months. Right kidney with large range of motion. Performed nephrorraphy Oct. 10, 1885. Catgut used, sutures included only the cellulo-adipose tissue surrounding the kidney. Kidney fixed except that it had a transverse motion of ½ inch, and there was marked relief of symptoms. Had patient wear an elastic band fixing a

truss pad of hard wood in the right hypochondriac region below the border of the liver. This patient was seen recently, and the kidney found with but slight motion, and entirely free from dragging. Case III.—Mrs. O., married, and mother of several children. Right kidney movable several inches, abdominal walls lax, so movement of kidney easily made out. Complained of dragging pain and obstinate nausea, and has an occasional attack of agonizing pain referred to the right kidney. Did nephrorraphy in July, 1886, by oblique lumbar incision. The movable portion of the perirenal cellulo-adipose tissue was stitched to the edges of the incision, two silk and four catgut sutures being employed. Patient made a good recovery, was relieved of the dragging pain, and has not had a recurrence of the intense pain which formerly came on at irregular intervals. Now at the end of nearly two years the kidney remains fixed, though the patient still wears a truss. The writer is now convinced that it is unnecessary to include the renal capsule or any of the renal tissues in the sutures, if that portion of the perirenal cellulo-adipose tissue most nearly surrounding the kidney and movable with it is securely stitched into the edges of the wound, and the patient is kept upon her back for several weeks.

Dr. Joseph D. Bryant (*Med. Record*, Jan. 12, 1889) reports a case which had previously been operated upon for stricture of the ascending colon: "A vertical incision was made just outside of the erector spinæ muscle, on the right side, from the lower border of the last rib midway between its extremities, downward nearly to the crest of the ilium. The outer border of the quadratus lumborum was exposed without difficulty. The anterior surface of this muscle then served as a guide to the location of the kidney, which could not be felt at this time, even when full pressure was made upon it in front. The anterior layer of the lumbar aponeurosis was then divided in a vertical direction. The kidney could then be felt by deep pressure, aided by counter-pressure. The transversalis fascia was then divided vertically to the same extent. The kidney could then easily be felt as it moved upward and downward with each respiratory act. It could not be seen on account of its fatty surroundings. Firm pressure in front now forced the kidney against the open wound, along with its fatty capsule. This capsule was easily and quickly torn through, bringing the kidney fully into view. The divided edges of the capsule were grasped with the fingers and drawn through the wound with abdominal pressure, and about three inches of the capsule were removed from each side. The kidney was now pressed into the wound by gentle pressure, and the borders of the capsule were then drawn taut, turned over the edges of the entire external wound, and sewed firmly to it with carbolized silk carried through the entire depth of the lumbar tissues. This measure confined the kidney in the wound, but did not control entirely the movements of the kidney caused by the act of breathing. However, gentle pressure downward and backward on the kidney, from in front, readily confined the organ quietly in position. I should add that a stitch passed through the fibrous capsule of the organ before this had been quickly torn out by the movements of the kidney. After the final sewing of the capsule the wound had the following dimensions: Length, four inches at the bottom; width, three quarters of an inch. The bottom of the wound was composed entirely of kidney, covered by the fibrous capsule. The wound was then drained and packed with iodoform gauze; a counter-pressure pad applied over the kidney in front, and the whole confined in position by adhesive straps and bandages. The patient made a rapid and continuous recovery without the intervention of an unfavorable symptom. Since the operation she has had no return of the old trouble, and has experienced no unusual sensations other than an occasional burning sensation at the seat of the kidney, and an indefinite sense of drawing, which I believe due to the contraction of the liberal cicatrix upon which reliance is placed to retain the kidney in the new position, aided by the shortened and tense fatty capsule which surrounds it."

Dr. W. W. Keen (*Med. News*, April 20, 1889) reports a case of floating kidney operated upon by him Oct. 26, 1888, in which stitches were passed through the capsule and substance of the kidney. On March 16, 1889, the patient reported that she was relieved of all her symptoms except a slight weakness in the back.

Mr. Lawson Tait (*Med. Record*, Sep. 21, 1889), says he regrets his operations of

nephrorraphy. None of the patients had been benefited, and one had since died under circumstances which might fairly be attributed to the operation. He would have nothing further to do with the operation.

GERTRUDE B. KELLY, M.D.

MEDICINE AND PATHOLOGY.

Browning (W.) on Severe Continuous Cephalalgia as an Early Secondary in Syphilis.—This form of headache is severe, prolonged, and continuous, more so than almost any other that we meet. There is no complete intermission. It is complained of as something foreign to the patient's previous experience. The whole scalp may be so tender ("sore") that the hair will be left uncombed. It is not localized to any spot or nerve-distribution, nor even to one side, but involves the whole cranium; whilst the headaches of late syphilis are more apt to be localized. It may be attended by delirium, especially at night, though it does not otherwise present as marked nocturnal exacerbations as do later troubles. Still it causes insomnia, and is altogether very exhausting, as the haggard countenance of the patient usually shows. It occurs predominantly, and in great severity perhaps exclusively in women. At least all those seeking treatment for the headache simply, were females. Still, all women who are thus infected do not have this symptom, even when fully aware of their disease.

In several of these cases the onset of this trouble seems to have antedated the outbreak of cutaneous symptoms by about three weeks. Hence, practically it may constitute the earliest secondary. This period, however, may be so much shorter that the symptom loses its importance, even appearing, with the advent of occult secondaries.—*Brooklyn Med. Jour.*, Nov., 1889.

Ward on Remarkable Emaciation of a Syphilitic.—A man aged forty-six, presented complete consolidation of the left lung and syphilis of the brain. His ordinary weight was 225 pounds, and when he presented himself he weighed 118. His temperature was 100°, his pulse 90. He expectorated profusely, and anorexia was complete. He improved under the mixed treatment with iron, and is recovering his health and his weight.—*Pittsburgh Med. Rev.*, Oct., 1889.

Mallet (G. H.) on Mexican Ideas concerning the Contagiousness of Tuberculosis.—The first death that occurred in my practice here happened to be a case of pulmonary phthisis. Immediately after the body was removed for interment, sulphur was burned freely throughout the house, the walls were scraped, and a fresh coat of whitewash applied. These precautions they use in no other diseases than yellow fever and phthisis. Of course, they are in utter darkness as regards Prof. Koch and the existence of the tubercle bacilli, the source of infection, etc., and could only have determined upon the infectiousness of pulmonary phthisis from observation.

It is a simple fact that, although they deny the hereditary transmission of pulmonary tuberculosis, they consider it a source of great mortification to have consumption or to be related to one affected with this disease. You may tell a man that he or his wife, or any of his family, has syphilis, and nothing is thought of it. He will simply inquire about the treatment, and does not care who knows of his trouble. But if the case is one of phthisis, he will request you to call it by another name and enjoin secrecy. The repugnance to any thing pertaining to phthisis is as great here as in some parts of California, where, for instance, to call a man a scoundrel is a small matter, but to call him a *consumptive* scoundrel means a fight.—*North Car. Med. Jour.*, Oct., 1889.

Experimental Articular Tuberculosis.—Dr. Pavlovski, in a paper recently published in the *Vrach*, gives an account of some researches he had made in Professor Pasteur's laboratory on the development and spread of articular tuberculosis, his special object being to find out whether the tubercle bacilli develop in the white corpuscles or in the connective tissue, or in both. In order to carry out his research he prepared cultures of tubercle bacilli in peptone glycerine, and injected the virus into the knee-joints of guinea-pigs, these joints being examined after the lapse of from half a day to eight weeks. After twelve hours the bacilli could be detected both in the connective-tissue corpuscles and in the white blood corpuscles. It was found that the white corpuscles play an important rôle in the production of

tubercle, undergoing a series of progressive changes until they assume an epithelioidal character, experimental tubercle consisting of epithelioidal cells due both to white blood corpuscles and to connective-tissue corpuscles. Dr. Pavlovski was also able to demonstrate the propagation of the bacilli along the course of the lymphatics, the nearer glands becoming first infected and subsequently those at a greater distance.—*Lancet*, Nov. 2, 1889.

Macdonald (A. D.) on the Convulsions of Reproduction and their Congeners.—The author concludes that puerperal convulsions depend upon an acute motor-neurosis arising from inflammatory action about the vaso-motor centre—the convulsions being the symptom, the inflammatory action the disease; and that the cause of this inflammation most frequently, but not invariably, also suffices to produce a renal hyperæmia.

Where no albuminuria is present, the case is explained by the existence of the vaso-motor centre-itis alone.

The convulsions are neither hysterical, epileptic, apoplectic, nor anæmic, but entirely *sui generis;* and that *temperature* forms an important factor in their diagnosis.

The treatment from which the most successful results have, as yet, been obtained, and on which the author would rely is—

(Operative.) *Accouchement aidé*, counter-irritation to neck and loins, and bleeding, which might be had recourse to in "sthenic" cases with full pulse, but he would not abstract (122 ounces) one hundred and twenty-two ounces of blood in seventeen hours, as Lever says he did from "a large muscular Irish woman."

(Medicinal.) Colchicum might be tried in some cases, but nitro-glycerine, chloral hydrate, morphia, aconite, and veratrum viride are the agents which have been shown to be the most efficacious, either as supplemental to the operative treatment above mentioned or otherwise.

The mechanical albuminuria of gestation is a curable affection with little risk when properly treated. Hysteria and epilepsy stand in similar positions to those diseases in the non-pregnant condition; but puerperal eclampsia, or the convulsions of reproduction, is a disease, provisionally so named, of the most formidable nature and difficulty of treatment—the pathology and treatment of which cannot yet be said to stand on an altogether satisfactory and rational footing—the logical "sufficient reason" not yet being found, and will not be so, until (if ever) the mysterious movements of nerve molecules and atoms be, to some wondering observer, revealed. Regarding it, however, from the nearer and coarser point of view, as an inflammation of a part of the central nervous system, we shall become more and more able to rescue its victims from its terrible grasp.—*Med. Press*, Oct. 30, 1889.

Hektoen (L.) on Cirrhosis of the Liver and Rupture of Varicose Veins in the Œsophagus with Fatal Hemorrhage.—A man of forty died of hæmatemesis on the day of admission. An autopsy revealed: right adhesive pleurisy; tubercular peribronchitis in upper lobe of right lung; interstitial hepatitis; enlargement of the spleen; chronic gastritis and ruptures of varicose veins in the œsophagus.

The mucous membrane of the œsophagus was pale and wrinkled, and in the lower four or five centimetres the submucous veins showed marked varicose dilatations. The varicose veins were best marked about 3 ctm. above the junction with the stomach, and here the larger trunks measured about two centimetres in diameter. These veins were thrown into quite regular convolutions, the bend of which had become saccular in some places. Between the main trunks there passed, also, varicose connecting vessels.

At this point, about four centimetres above the lower end of the œsophagus, a circular opening into a sacculation could be made out quite distinctly, together with a small circumscribed loss of œsophageal mucous membrane. These openings appeared as small red areas, and upon pressure over the corresponding vein from below upward, a little blood could be made to pass out of each opening.—*North Am. Practitioner*, Nov., 1889.

Duncan (B. A.) on a Case of Tetanus Caused by Intestinal Irritation.—I was summoned during the month of February to see a colored girl of twelve, who was suffering with the most violent attack of tetanus that I had ever seen. I found her resting upon her head and heels in a state of complete opisthotonos, with the jaws firmly closed and the head drawn to the left side. Every muscle in her body seemed to be rigid except those employed in deglutition. Her arms were forcibly

flexed, and the muscles of the abdomen were as hard as a brick. After a careful examination I found that there was no traumatism, and I at once suspected that worms in the alimentary canal were the cause of the trouble, and calomel and santonine were given in decided doses, followed by castor oil and turpentine. Her bowels were obstinately constipated and refused to respond to this treatment. Enemas were then given, upon which she passed a large ball of lumbricoids containing about thirty worms, half of which were dead. Her muscles would relax only when under the influence of chloroform administered by inhalation. The bromides, chloral, Indian hemp, and morphia were also used, but they gave only temporary relief. Finally I gave her the tincture physostigmatis, prescribed a generous diet with stimulants, and an occasional laxative. She remained in this rigid condition more than a month, but she is now as healthy and well developed as any young woman in this county. I was fully convinced then, and am now, that this species of worms was the specific cause of her condition.—*Jour. Am. Med. Assn.*, Nov. 9, 1899.

[The continuance of the spasm for so long a time after the expulsion of the worms would seem to cast some discredit upon the author's theory of the etiology of the spasms.—Ed.]

THERAPEUTICS.

Watkins (W.) on Results Following the Administration of Antipyrin.—A woman, thirty-seven, during a slight attack of gastro-intestinal catarrh with jaundice, complained of a severe nervous sick-headache in the course of the illness. I prescribed ten grains of antipyrin, which entirely removed the ache, but within half an hour the upper lip had greatly swollen, and continued to do so for another quarter of an hour, by which time it was at least double its normal size. The swelling disappeared almost as rapidly as it came, and in three hours from the time of taking the drug the lip was its natural size. There was no other apparent cause operating.—*Lancet*, Nov. 2, 1889.

Resorcin in Whooping-Cough.—Dr. Justus Andeer, who had previously written in recommendation of the employment of resorcin in whooping-cough, has recently published some fresh cases illustrating, as he believes, the advantages of this method of treatment. One of the patients was his own child, a little girl of seven years of age, who during an epidemic of measles and whooping-cough was attacked by the catarrhal form of the latter affection and suffered severely for a week, notwithstanding a change of climate. He then prescribed an ounce of a 2-per-cent.-solution of resorcin four times a day, part of which solution the child was to gargle, and part of which she was to take. This very soon began to show signs of affecting the course of the disease, for on the second day the fits of coughing were perceptibly diminished, and in eight or ten days the child was quite free from cough. Five other children, who had been unsuccessfully treated for some time, immediately began to improve under the resorcin treatment. In the case of a baby of six months old a sweetened solution of the strength of ½ per cent. was given by means of a feeding-bottle and answered admirably.—*Lancet*, Nov. 2, 1889.

Duke (A.) on Resuscitation of Asphyxiated Infants.—As an addition to the plans in general use for the resuscitation of an asphyxiated infant may I suggest the following method, which I have found both simple and effective in all cases where I could hear the heart's beat. Directly the infant is born and I see no signs of life, I request the nurse to take charge of the uterus and thus proceed: Should I find the funis pulsating strongly I wait till this has almost ceased and then divide it. I then raise the limp and flaccid body of the infant, and turning it face downward, with arms and legs pendent, allow the thorax alone to rest across the open palm of my left hand, and at intervals of five seconds (which I measure by counting slowly) compress the ribs with my hand, as one would work a rubber syringe. While my left hand is thus fully occupied, the position of the head allowing the tongue to fall forward and facilitate the escape of mucus from the mouth, I cleanse the lips of infant with napkin held in my right, and insert my index finger well into the pharynx so as to establish the "atmospheric highway." I then proceed to change the child to my right hand so that the tips of my fingers resting near the heart will at once detect any improvement in its action. If I do not find this satisfactory I plunge the

child into a large basin of hot water, rubbing the chest and back vigorously: the latter I consider more important as the friction to spine without doubt stimulates the respiratory powers, and a little spirit poured over the back by the nurse and well rubbed in is also efficacious (in conjunction of course with the artificial respiration which has been kept up as regularly as possible).

Some years ago while assistant master at the Rotunda Hospital I was called to a case of post-partum hemorrhage, and having attended to this, which took some considerable time, I inquired where the infant was, and was told it was still-born. I found it under the bed with a heap of soiled linen, fortunately, the heart still beating, though very feebly. By adopting the treatment I have endeavored to describe I had the satisfaction of saving the infant's life, much to the disgust (I regret to say) both of the mother and friends, who had evidently intended it should not live. In conjunction with the treatment before enumerated I have sometimes found it advantageous to suspend the infant by the legs downwards with back close to fire keeping up respiration with the free hand. It is most important that the infant should respire fully and shout lustily so as to fill the lungs with air. The disregard of this measure frequently gives rise to what is known as atelectasis, which defect in the respiratory function lasts through life.—*Med. Press*, Oct. 30, 1889.

Fatality under Nitrous Oxide Gas.—The patient, was a woman aged seventy-one, of stout build, and under treatment for fatty degeneration of the heart. She had been referred to the dentist by her medical man, in order to have two teeth removed and an opening made into the antrum. It appears that the patient very much dreaded the operation, and was heard to remark she feared she would not survive it. At 9 A. M. she breakfasted, but it seems her food remained wholly undigested, for during the performance of artificial respiration, undertaken when breathing ceased, it was ejected unchanged. The operation took place at noon. The dentist noticed whilst he gave the gas that the patient breathed very shallowly, and he begged her to inspire more forcibly, but this she failed to do, for, as was afterwards discovered, her corsets and clothing were so tightly bound round her that normal breathing was simply impossible. As soon as consciousness had gone the teeth were extracted and the antrum perforated. It was then observed by the dentist and his assistant that the patient had become livid, had ceased to breathe, and her heart had stopped beating. Although artificial respiration was resorted to, the tongue being drawn forward, while the stays were with difficulty slit up with a knife, and nitrite of amyl exhibited, she never showed signs of life. Medical aid was promptly summoned but in vain. That nitrous oxide will be blamed is certain, but a dispassionate consideration of the circumstances seems to point rather to the neglect of precaution on the part of the patient than to any particular danger from the anæsthetic. It is clear she died from mechanical rather than from poisonous agency. Persons, even with fatty heart, although of course they are the least adapted for any kind of anæsthetic, take nitrous oxide with impunity; but the recumbent posture, with absolutely loose clothing and a stomach not distended with gases and undigested food, are conditions which can hardly be omitted without grave risk.—*Br. Med. Jour.*, Oct. 19, 1889.

Lees (D. B.) on the Treatment of Pneumonia by the Ice-bag.—The author reports five cases of pneumonia in which immediate and final arrest of the pyrexial process followed the application of the ice-bag; two cases where a relapse followed the removal of the ice-bag; and three cases in which a relapse followed its removal and a second fall of temperature occurred when the ice was reapplied.

He also reports two cases where relapses occurred while the ice was being continuously applied, the relapses being apparently due to implication of fresh portions of lung; four cases in which no immediate arrest of the pneumonia followed the application of ice, but obvious relief to symptoms resulted; and two cases in which no very obvious benefit resulted from the use of the ice-bag. All the cases recovered.

The author concludes that there is reason to believe that the ice-bag applied over a pneumonic lung has a directly curative influence; that it does not simply reduce the general temperature, but that it distinctly tends to repress the inflammatory process in the lung, with more or less success according to the severity of the case, and the height which the inflammation has

already reached. This is true, whatever theory of the causation of the disease be adopted. Coccus or no coccus, the ice-bag benefits an ordinary pneumonia.—*Lancet*, Nov. 2, 1889.

Weaver (J. J.) on Hyoscine as a Sedative.—In February, 1888, I obtained some hydro-bromate of hyoscine, and with considerable hope made use of it. Among several other cases I remember distinctly two cases in which I gave the drug. The first was a case of melancholia in a man rather above middle age, with great restlessness and sleeplessness at night. The hyoscine had not the slightest effect in quieting this patient, but rather the reverse, as after it he expressed himself as absolutely afraid to have a second dose, lest, as he said, it should quite drive him out of his mind. The second case was one of paralysis agitans, accompanied by great sleeplessness at night. In this case, too, the hyoscine entirely failed; whereas afterwards the tincture of hyoscyamus, as recommended by Charcot, had a most marked effect in producing sleep for a time. Subsequently I used the hyoscine as a general hypnotic in the wards for some time, but found it so uncertain that although I still have a little of the drug in hand, I have never since prescribed it.—*Lancet*, Nov. 2, 1889.

Collins (E. T.) on Cure of Amenorrhœa by Shock.—M. M., single, aged 35, strong, healthy, and robust girl, suddenly ceased to menstruate two and a half years ago without apparent cause. No suspicion or indication of pregnancy was present, afterwards verified by time. She did not complain of any subjective symptoms except monthly, when slight headache, backache, and *malaise* were felt for a few days. Her medicinal treatment was varied from time to time without any favorable result. Last June, returning in the evening from a country walk, she was suddenly alarmed by a tramp on the roadside, and was very much frightened. Her catamenia commenced that evening, and she has had three regular periods since, perfectly normal.—*Br. Med. Jour.*, Oct. 26, 1889.

Churton (T.) on Suspension for Locomotor Ataxy.—Case I.—A. M., aged 51, admitted February 18, 1889. Usual symptoms and signs in legs; incoordination of hands; difficulty in making fingers meet, picking up pins, etc. No sensory disorders except slight tactile impairment in feet and legs; has smoked much. Three years ago first found legs unsteady; unable to work for six months. Suspension ordered, but the apparatus was out of repair. While it was being mended patient improved so much that it was not used. On March 23d, he went out greatly improved, not having undergone suspension at all.

Case II.—T. O., aged 39, was admitted on April 17, 1889. Gait very unsteady; when feet are placed side by side he sways much; if eyes are then closed he falls; co-ordination impaired in hands and arms; pupils react to accommodation but very slightly to light; syphilis 20 years ago, married 14 years; three children alive and well; wife had two miscarriages; seventeen months ago felt want of power in right arm and leg; thenceforward ordinary history.

May 22d, suspension for five minutes, toes just touching the ground; felt no discomfort. The suspension was continued daily until June 3d, when it is noted that there was not the smallest improvement in any way; indeed, he was worse. On June 10th he was made out-patient, "decidedly more ataxic than on admission." As there seemed to be no reason why suspension should be expected to do good in such cases, I have not again subjected any similar case to the treatment. Dr. Saundby's cases strengthen my own impression that the method will be found useless.—*Br. Med. Jour.*, Oct. 12, 1889.

[Had suspension been employed in the first case it would have gotten the credit of the spontaneous improvement which ensued. To such cases as this all the good reputation of the method is due.—Ed.]

Weigert's Hot-Air Apparatus for Phthisis. — Experiments were recently made in Professor Bozzolo's klinik for the purpose of determining whether the air inhaled through Weigert's hot-air apparatus really reached the lungs in a sufficiently heated state to kill such tubercle bacilli as it came in contact with. For this purpose a thermometer was inserted into the trachea of a dog and the beast was then made to inhale the air of a temperature of 180 deg. The thermometer never showed a temperature higher than that taken simultaneously in the rectum, in fact it was constantly half a degree lower than this. Startling as the result may be at first sight, it is easily and

completely explicable by the evaporation of water by means of which heat is rapidly extracted. Some further experiments led to conclusions from which the following were formulated:

1. A current of air of a temperature of 180 to 200 deg., cools down rapidly on passing over a moist gauze.

2. The temperature of the air, whether in the bronchi or the trachea, even immediately below the larynx and the fauces is never higher than that in the rectum, but on the contrary half a degree lower.

3. If a person inhales hot air the expired air is saturated with moisture and is exactly of the same temperature as if the air of the temperature of 18 deg. had been inhaled.

4. The respirations become deeper and a little more frequent when air is inhaled hot than when it is cold.

5. Whilst expired air is generally warmed at the expense of the blood temperature, and the blood in the carotid shows a lower temperature than that of the tissues, when the air is warmed by the Weigert apparatus the expired air is warmed by it.—*Med. Press*, Oct. 30, 1889.

SURGERY.

Cleanliness versus Antiseptics in Surgery.—The question may be summed up in the remark that success in surgery is the reward of perfect cleanliness. Antiseptics, as such, are not necessary, still less indispensable, and, on the contrary, they may prove injurious either by giving rise directly to symptoms of poisoning by absorption, or by leading the surgeon into a feeling of false security, and so inducing him to overlook the vital precautions which alone can be relied upon to keep off the pathogenic microbe. It is none the less to the glory of Lister and of British surgery that the secret of his success lies in one only of the several principles enunciated by him, and the advance is none the less real because, in the first instance, its true source was overlooked.—*Med. Press*, Oct. 30, 1889.

Hill (A. P.) on Dislocation of the Penis.—I was called on the night of August 8th, to see a negro boy about thirteen years of age, who had the evening before become entangled in a hay rake, the pin holding the wheel tearing off the front of his pants and inflicting an extensive lacerated wound of the scrotum and contusions of adjacent parts. The wound extended transversely across the scrotum two inches in length, opening the cavity of the tunica vaginalis and exposing the testicles.

After thorough antiseptic irrigation of the wound, a number of interrupted sutures were used to close it and antiseptic dressings applied. The patient complained of no pain or uneasiness in the penis, and accordingly I left him without making any examination of that organ. The next morning I was urgently called to the patient, the messenger saying that since the accident he had been unable to pass water. I found the bladder very much distended and the genitals considerably swollen. On careful examination, instead of the penis, I found only the cutaneous sheet of that organ.

The body of the penis had disappeared, and owing to the swollen condition of the parts, I could not ascertain the new resting-place of the organ. Ether having been administered, a grooved director was passed into the sheath to its base and the penile integument split open to the pubes, and the index-finger inserted, I found the body of the penis lying under the integument of the abdomen, its axis corresponding with the linea alba. With but little difficulty the body was brought into its sheath, a catheter introduced, and the urine evacuated, the wound closed with catgut sutures and dressed antiseptically. The patient recovered in about ten days, and in two weeks afterwards I operated on him for convergent strabismus, the operation being followed by complete success.—*Nashville Jour. of Med. and Surgery*, Oct., 1889.

Senn on Early Laparotomy for Catarrhal and Ulcerative Appendicitis.—At the close of a paper on this subject, embodying the report of two successful cases, the author concludes that all cases of catarrhal and ulcerative appendicitis should be treated by laparotomy and excision of the appendix as soon as the lesion can be recognized.

Excision of the appendix in cases of simple uncomplicated appendicitis is one of the easiest and safest of all intra-abdominal operations.

Excision of the appendix in cases of appendicitis before perforation has occurred is both a curative and prophylactic measure.

The most constant and reliable symptom indicating the existence of appendicitis are recurring pains and circumscribed tenderness in the region of the appendix.

All operations on the appendix should be done through a straight incision parallel to and directly over the cæcum.

The stump, after excision of the appendix, should be carefully disinfected, iodoformized, and covered with peritoneum by suturing the serous surface of the cæcum on each side over it with a number of Lembert stitches.

The abdominal incision should be closed by two rows of sutures, the first embracing the peritoneum, and the second the remaining structures of the margins of the wound.

Drainage in such cases is unnecessary and should be dispensed with.—*Jour. Am. Med. Assoc.*, Nov. 2, 1889.

Bryant (J. D.) on the Treatment of Hernia.—The author concludes:

1. When gangrene of the intestine has taken place and the condition of the patient will permit, intestinal repair should be practised at once, and the gut returned to the abdominal cavity.

2. When gangrene has occurred, presumptively involving a portion of the upper two-thirds of the intestine, intestinal repair should be practised at once, and the gut returned to the abdominal cavity, even if the immediate result of the operation be somewhat doubtful.

3. When gangrene has occurred and the condition of the patient will not permit immediate operation, a temporary artificial anus should be formed.

4. It is better to form an artificial anus, under all circumstances, when the medical attendants are not familiar with the details of intestinal surgery.

5. Division of the constriction is not always necessary, and is often unwise when the formation of an artificial anus is contemplated.—*Med. Record*, Nov. 9, 1889.

Jackson (A. R.) on A case of Abdominal Lipoma Simulating Ovarian Tumor.—A multipara, previously in good health, had for two years complained of pelvic pain, abdominal enlargement, and an increasing cachexia. An elastic semi-fluctuant tumor was found, extending from the pelvis to three inches above the umbilicus. A laparotomy showed this tumor to be a lobulated lipoma, springing from the peritoneal folds of the mesentery and the retro-peritoneal space. It was not removed, the wound was closed, and the patient recovered. These tumors are excessively rare. Cases have been reported by Péan, Spencer Wells, Barbour, Byford, and Homans. The tumors in all cases were retro-peritoneal. The diagnosis in all had been faulty, and all but two of the operations had resulted fatally.—*Boston Med. and Surg.*, Nov. 7, 1889.

MISCELLANEOUS.

Williams (C. B.) on Torticollis Greatly Improved by Toxic Doses of Gelsemium after Failure of Myotomy.—A man aged twenty-four was admitted to the Polyclinic Hospital October 24, 1888. His family history was good. His previous history negative, excepting that he has had several slight attacks of torticollis, and a number of falls upon the shoulders and neck, and has suffered from rheumatism. In the autumn of 1886 he noticed a jerking of his head and neck to the left side, associated at times with severe pains. This continued and gradually grew worse for a year, when he began to have also twitchings of the left arm and leg. He soon lost entire control of the left foot and could not stand properly. After three months of medical treatment he began to have more control of his leg. When he first came under observation he described the muscular twitching as being more like a tremor. While the patient was sitting quietly no spasm was noticed, but on attempting to walk, use his arms, or move his head, a cramp or spasm occurred in the muscles of the neck, and his head was turned to the left. The chin and face did not turn *upward*, as would be the case if the right *sterno-cleido-mastoid* muscle was affected, but rather horizontally and outward; hence it was believed to be the splenius capitis muscle of the left side that was affected. Any voluntary muscular action would cause the spasm. On November 2, 1888, a myotomy was performed by Dr. John B. Roberts upon the muscle that was supposed to be the source of the torticollis, but with no beneficial results. Dr. Roberts furnished the following description of the operation:

"On account of the peculiar twist of the head, which seemed to imply that the splenius capitis was at fault, I determined

to divide the left splenius capitis instead of the right sterno-mastoid. Accordingly, on November 2d I exposed the muscle, and proceeded to do a partial myotomy, dividing the belly of the muscle throughout its entire thickness, but leaving a band of fibres upon each edge intact, hoping in this manner to weaken without destroying muscular action. This was done because it was not absolutely certain that I was cutting the muscle which produced the spasm, and, in order that I might at any time during the after-treatment bring the fibres together, if the torticollis was not improved, I introduced a wire suture through the cut edges, crossing the ends and bringing them out through the skin, thus causing a loop underneath the skin, so that traction on the ends would draw the muscular bellies together. For a day or two some improvement was perceptible, which caused me to withdraw the suture and allow the fibres to remain retracted. The head and neck for some time was kept in position by a plaster-of-Paris bandage, and it was believed that something was gained by the operation. Within two weeks, however, the spasm returned. I then made a subcutaneous division of the splenius muscle with so much freedom that I believed I had divided all its fibres. The results were again unsatisfactory. There was temporary improvement, but it soon became evident that the condition was practically no better. Any violent motion, such as walking or the use of his arms, at once brought on a spasm, in which his head was twisted to the left, with considerable pain in the back of the neck and in the shoulder of the left side. Rigid muscles could also be felt in the splenius region."

Electricity was also used without benefit. He was next placed upon the fluid extract of gelsemium in ordinary doses, but without relief. Dr. S. Weir Mitchell then suggested hyper-physiological doses of the drug.

On December 29, 1888, the patient was admitted to St. Agnes Hospital in an unchanged condition. He was placed upon full doses of the tincture of gelsemium without the production of any physiological effect. He was then placed upon full doses of Wyeth's fluid extract of gelsemium, the dose being gradually increased so that by February 1, 1889, he was taking twenty-three drops three times a day.

The physiological action of the gelsemium was now manifested by dilatation of the pupils, languor, some headache, and flushing of the face, with slight attacks of giddiness; the patient describing his sensations as though a band were tied around the forehead. On February 4, 1889, he was taking ten grains of the salicylate of sodium, and five of iodide of potassium three times daily, with eighteen drops of extract of gelsemium four times daily. On March 15, 1889, the administration of other drugs was discontinued and the gelsemium increased to twenty-four drops four times daily, with the same effects as above noted. The patient, who was intelligent, was allowed to regulate the dose of gelsemium according to its physiological effects, being instructed to take the largest possible dose. The patient, much improved in his condition—in fact, almost entirely free from pain or spasm, was discharged from the hospital March 26, 1889, and subsequently returned to work.

A letter from him, dated June 9, 1889, stated that at that time he was still improving, and was taking ten to fifteen drops of the gelsemium five times daily. He had found that twelve drops of a preparation of gelsemium from Allegheny City were stronger than thirty drops of that obtained in Philadelphia, showing how great is the difference in the relative strength of preparations of powerful drugs as prepared by different chemists.

The commencing dose of gelsemium should never be greater than two or three miniums, as alarming symptoms have been caused by larger doses. It seems remarkable that this patient could take such enormous doses apparently with no ill effect.—*Med News*, Nov. 16, 1889.

Iodoform Gauze in Post-Partum Hemorrhage.—Dr. O. Piering, assistant in Prof. Schauta's obstetric clinic in Prague, has published his experience in the employment of Dührssen's plan of plugging the uterus with iodoform gauze for post-partum hemorrhage due to an atonic condition of the organ. Dührssen recommends that, when post-partum hemorrhage comes on, the bladder should be emptied, and forcible friction and intra-uterine irrigation of hot or cold water, along with ergotinin hypodermic injections employed; that if the hemorrhage still continues, the cavity of the uterus should be filled with iodoform gauze, the irritation produced by this setting up active and permanent contraction. The method has, according to

Dührssen, the advantages of great certainty, complete harmlessness, and facility in its performance. Olshausen, Veit, and Tehling, however, say that the contraction set up is not always permanent, and that the method is not so free from danger as Dührssen believes. In consequence of these conflicting views, Dr. Piering resolved to give the method a trial, and he details several cases in which he employed it with complete success. In no case was any harm done by it. He advises that resort to the plug should not be too long delayed, and he prophesies an important future for the plug of iodoform gauze in post-partum hemorrhage.—*Lancet*, Nov. 9, 1889.

Minges (G.). Bacteriological Examination of American Mineral Waters in the Bottled State.—In the course of his paper the author introduced the following synoptical table :

Name of water.	No. bottles contaminated out of 12.	No. ccm. of CO_2 to the gallon of water.	Average No. microorganisms to 1 ccm.
Arcadian . . .	1	Artificial . . .	52
Bethesda . . .	1	Artificial . . .	85
Congress . . .	1	312.289 . . .	93
Salutaris . . .	2	Original CO_2 allowed to escape, and artificial CO_2 substituted	59
Geyser	2	454.02	85
Silurian . . .	2	Artificial. . . .	100
Buffalo Lithia .	2	. . . . .	100
Rockbridge Alum . . .	2	. . . . .	863
Hathorn . . .	2	375.747 . . .	68,290
Empire . . .	3	344.669 . . .	1,407
White Rock . .	4	Artificial . . .	2,218
Excelsior . . .	4	250	8,417
Manitou . . .	5	Recharged with its own Co_2 .	886
Colfax	10	. . . . .	17,103
Henk	10	Artificial . . .	25,000
Blue Lick . . .	12	. . . . .	1,922
Columbian . .	12	272,06	2,973
Bethesda . . .	12	Non-aërated . .	3,505
Castalian . . .	12	. . . . .	40,189
Crab Orchard .	12	. . . . .	150,000

The conclusions arrived at by the author from his bacteriological studies are as follows :

1. The bacteria is bottled mineral waters are probably not derived from the spring, in the majority of cases, but are due to contamination from the bottles and corks, the cleansing methods now in vogue being insufficient to destroy them.

2. Carbonic acid in a bottled mineral water has a powerful inhibitory influence on the development of germs, whether the gas is natural to the water, or has been artificially generated and added to it. When the proportion of CO_2 is 350 cubic inches or more to the gallon, the retarding influence of the gas is very great. It is much less when the proportion is only 250 cubic inches to the gallon. But among every dozen bottles of even the most highly carbonated waters there is at least one which contains more than 250 microörganisms to every cubic centimetre, and ten even out of twelve bottles may be thus contaminated. When the water is charged artificially some time may be given for contamination before such charging is accomplished.

3. Sulphuretted hydrogen gas, in the proportion contained in mineral waters, probably has some inhibitory influences on the development of germs, but not to the extent which might be *a priori* expected.

4. As regards freedom from bacterial contamination, most of our native carbonated mineral waters are superior at least to the most popular European waters of the same kind.

5. The non-aërated so-called table waters are probably very inferior to ordinary hydrant water.

6. The strongly saline non-carbonated mineral waters are so badly contaminated as to be wholly unfit for internal administration in the form in which they are at present put up, unless the germs are previously destroyed by heating (for two hours at 70° C.—Reinl).

7. In order to bottle at least a non-carbonated mineral water in such a way that it will remain bacteriologically pure for an indefinite period, the bottles should first be boiled or steamed, kept in an inverted position in a place free from dust until cool, then immediately filled and closed with boiled corks.—*Jr. Am. Med. Assn.*, Nov. 16, 1889.

Smith (F. T.) on a Case of Persistent Pupillary Membrane.—Male—æt. 18. Membrane in right eye consisted of four threads attached to the anterior surface of the iris at the greater circle, and to a wedge-shaped opacity on the anterior surface of the lens capsule. One pair ran upward and outward and were of equal thickness throughout, looking like fine threads ; the other ran downward and outward from the opacity, making a right angle with the first pair. There was a fan-shaped enlargement at the point of attachment to the iris. There was hypermetropic astigmatism. The other eye was normal, but there was a small amount of hypermetropia.—*Va. Med. Mo.*, Nov., 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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OBSTETRICS.

Garrigues (Henry J.) on Corrosive Sublimate and Creolin in Obstetric Practice.—The author reviews carefully his extensive experience with corrosive sublimate, and analyzes eighteen fatal cases that have been reported as following its use, with two of his own. His conclusions are that :

I. The solution of bichloride of mercury used for vaginal and intra-uterine injections ought not to be stronger than 1 to 5,000.

II. No more than one to one and a half quarts should be used.

III. The fluid should be removed from the uterus and the vagina.

IV. No injections should be used in normal cases after the birth of the child.

V. Intra-uterine injections should not be given oftener than once or twice in twenty-four hours, vaginal every three hours.

VI. The symptoms and signs of absorption should be constantly looked for, and the use of the bichloride discontinued at their first appearance.

VII. The injections should not be used on patients suffering from anæmia, abortion, kidney diseases, or diarrhœa.

VIII. It is safest to abstain from the mercurial injections altogether until experience shows that the corrosive sublimate gives better results than any other antiseptic.

IX. Corrosive sublimate should be used for disinfection of the outer surface of the patient, for the hands of doctors and nurses, and for materials brought in contact with the patient.

X. Carbolic acid is, perhaps, as dangerous in injections as corrosive sublimate.

XI. Other effective germicides may occasionally answer a good purpose.

XII. Creolin is an excellent antiseptic, little poisonous, a powerful hæmostatic, and makes all surfaces slippery—properties that recommend it especially in obstetric practice.—*Am. Jour. Med. Sc.*, Aug., 1889.

Ellisen (W. A.) on Two Years' Detention of a Dead Fœtus.—After an apparently normal pregnancy, the patient had labor pains come on, of moderate strength, not at long intervals. The physician in attendance found the cervix very high, hard, and elongated. He could not make out the presenting part. The pains died away, and in a few days a slight fœtid discharge appeared. The physician, believing the child to be dead, tried to persuade the patient to allow him to deliver it ; but she refused, and went on with her housework. Eighteen months after the date of the expected confinement, the menses which had appeared irregularly, stopped. During the next twelve months, the patient suffered pains at intervals in the uterine region, and lost much flesh. The uterus was now more easily outlined, was globular, very hard, somewhat nodulated, extended to about two inches above the umbilicus. A very offensive discharge continued to pass from the vagina The os was very hard, high up, and somewhat enlarged. A small probe could not be passed through the cervical canal. The cervical canal was very long, small and tortuous, and the tissues hard, tough,

and resisting. Some months later, the patient was cloroformed and an attempt was made to dilate the cervix, but with little success. A sound was then passed up some distance, and was believed to have entered the uterine cavity; but, as the autopsy showed, the sound had left the cervical canal at the point of obstruction, about two and a half inches from the os, and passed up into the tissues of the uterine wall, and out into the peritoneal cavity. About fourteen hours later the patient died. On opening the abdomen the uterus was found bound by adhesion on all sides. The uterine walls were very thin. On opening the cavity of the uterus, a fœtus of eight or nine months was found very much decomposed. An examination of the cervical canal showed it to be tortuous, narrow, long, and unyielding. It was the opinion of the physicians at the autopsy, that the only way the fœtus could have been delivered, would have been by Cæsarian section.—*Nashville Jour. of Med. and Surg.*, July, 1889.

Westervelt (J. D.) on a Case of Triplets.—A colored primipara of twenty-three gave birth to triplets at the seventh month. The presentation of the first was normal. The second was a breech, following in twenty minutes. In twenty minutes more came the secundines with the third fœtus intact in them. When this sac was opened the fœtus was found mummified and much flattened, and not more than half the size of either of the others—all females. Development of the third had evidently been arrested a month or more, but owing to the preservative properties of the liquor amnii there was no observable fetor. Each fœtus was in its own sac, but the sacs had a common central union. Three coins placed in a tangent circle gave a fair diagram of these placentæ.—*Atlanta Med. and Surg. Jour.*, Aug., 1889.

Allport (W. W.) on Facial Neuralgia Consequent upon Pregnancy.—The author cites the numerous causes of neuralgia in the non-pregnant state, to show that it is more probable that in pregnancy neuralgia of the face is due to some other cause than reflexes from the pregnant womb. It is stated as a fact that neuralgias of pregnancy are more commonly in the upper than in the lower extremity. The hydræmia of the blood in pregnancy is believed to be the most important factor in the etiology of this disorder. Another fact bearing on the point, is that all below the diaghragm is in a constant state of venous hyperæmia, while that above is in a constant state of arterial hyperæmia, and arterial tension with its muscular expansion and contraction is always a fruitful source of nerve irritation and pain. Moreover, it is easier to conclude that facial neuralgia in pregnancy is reflected from the nerve irritation of the stomach, rather than from the uterus; for irritation of the stomach is a well-known cause of this symptom. In a majority of cases the sweat glands of pregnant women are found to be in an abnormal state of functional activity. The face does not escape this condition, and with almost constant exposure to atmospheric influences, the nerves of the face are particularly liable to those atmospheric impressions that are so productive of pain.

Gingivitis is another source of irritation to which these subjects are peculiarly liable. The teeth are hence more liable to irritation and decay from the action of external agents. A starved condition and retrograde metamorphosis of the nerve fibrils of the tooth structure is established. This is sufficient to lead to the agonizing neuralgias, spoken of by Anstie, which occur under circumstances of impaired nutrition, incident to a wasting of tissue or bodily decay.—*Jour. Am. Med. Ass'n*, Aug. 17, 1889.

Cullingworth (C. J.) on Dressings for the Umbilical Cord.—The writer advises the free use of starch powder as the best dressing for the cord before its separation. It had been suggested that finely powdered boric acid, or some compound into which boric acid entered as an ingredient, would be preferable to pure starch. But the author's experience at the General Lying-in Hospital has shown that the property of deliquescence possessed by boric acid unfits it for this particular purpose, preventing, instead of aiding, the normal desiccation of the cord, and delaying its separation. Instead of falling off on the fourth or fifth day, cords dressed with boric acid seldom come away before the eighth day.—*Br. Med. Jour.*, Aug. 24, 1889.

McNamara (J. G.) on Reflex Neuroses in Puerperal Insanity.—The author believes that puerperal mania and puerperal eclampsia are the effects of the

same pathological conditions which are so often found to exist in child-bearing women, and that the primary exciting cause of those conditions is reflex nervous irritation, more severe in the latter than in the former disease. He thinks that the products of a former pelvic peritonitis, a metritis, or cellulitis exercise a potent influence in the causation of puerperal mania; that those previously existing conditions may leave a complicated cervical canal, a stenosed os uteri, or thickened cellular tissue. When this cellular tissue is forced to undergo the changes that must necessarily take place during the course of gestation and parturition, it sets up an irritation of that intricate and sensitive portion of the nervous system which is supplied to the female procreative organs. This irritation in turn is reflected back to all the centres connected with puerperal insanity.

Skene favors this theory, as he says in his treatise on the diseases of women: "Organic diseases of the sexual organs exercise a most important influence in causing insanity, and tend to retard recovery from it."—*Northwestern Lancet*, Sept., 1889. E. S. B.

REPORT ON ORTHOPÆDIC SURGERY.

BY JOHN RIDLON, M.D.

By far the most important paper on orthopædic work which has come to our notice during the present year is the *Abstract of Three Lectures on Tuberculosis in Some of Its Surgical Aspects* (*Brit. Med. Jour.*, July 13, 20, and Aug. 3, 1889), delivered at the Royal College of Surgeons of England, by Howard Marsh, F.R.C.S. We shall therefore make no excuse for quoting freely therefrom.

After subscribing to the view that tuberculosis is a parasitic disease essentially dependent on the bacillus tuberculosis, the lecturer spoke of the various influences which bear upon the production of a fitting soil in which the bacillus may be developed, and continued:

1. One of these is the influence of inheritance. This is universally recognized. I have notes of a family of four children whose father and mother both died of phthisis. Of these four, one died of caries of the spine, and the remaining three had hip disease, and were patients at different times at the Hospital for Sick Children. In all excision of the joint was performed, but in all the operation failed, as previous treatment had, and all these children ultimately died of the disease.

Yet, although such examples show how strong the influence of inheritance may sometimes be, its effect is often much exaggerated. I have frequently seen children who were descended from phthisical parents, and who have been attacked with tuberculous disease of the spine or a large joint, recover under favorable circumstances, and remain perfectly sound; the only noticeable features in their case being that recovery was slow, and that relapses were for some time very easily provoked. Indeed, if appropriate treatment is adopted in the early stage of this disease, recovery so frequently follows, in spite of a strong family history of tuberculosis, that the fact that a patient comes of a highly tubercular stock need not prevent our anticipating a perfectly sound and permanent recovery. The two following cases will serve to illustrate this fact.

2. Any thing which impairs the general health is well known to act as a predisposing cause of tuberculosis. Fortunately, the converse of this is equally true—that, when conditions unfavorable to the general health are removed, sound recovery from tuberculous disease, if this is not far advanced, will often follow.

3. The influence of age deserves careful attention. A large majority of all cases of tuberculous disease of the spine, joints, cancellous bone, and lymphatic glands begin between the third and the eighth years of childhood, and, though they undoubtedly occur after this period, they become more and more rare as age advances. I am, moreover, convinced that, as a very general rule, the active period of these and similar affections is limited in duration, in other words *transitory*. It appears, broadly speaking, to extend, in different instances over from two or three, to five or six years, and to lie somewhere between the ages of three and nine. It is during this period that surgical tuberculosis most frequently sets in, and that it shows a strong tendency to advance. But when this time has elapsed, often no further outbreak occurs, and sound repair takes place. I may briefly relate two cases to make my meaning clear.

This experience as to the transitory nature of the tuberculous tendency, although it does not often attract attention, is certainly by no means novel. Every surgeon is familiar with instances in which, even after long-continued and destructive disease of the spine, or of one of the large joints, the time has come when the tubercular process has ceased, and recovery, with firm ankylosis, has ensued, and the patient has remained years afterwards in the enjoyment of robust health.

There is a fact in connection with age, in respect to tuberculosis, which demands particular notice. It is that surgical tuberculosis and phthisis are prevalent at different periods, and are, speaking broadly, separated from each other by an interval of between five and fifteen years. Indeed it is remarkable that pulmonary phthisis and surgical tuberculosis very seldom occur together, or as complications the one of the other. At the Alexandra Hospital for Hip Diseases phthisis is very rarely met with, while, on the other hand, I am informed by Dr. Douglas Powell that at the Hospital for Consumption at Brompton tubercular disease of the joints and caries of the spine are scarcely ever met with among the patients with tubercular phthisis.

4. Another influence which favors the growth of the bacillus tuberculosis—that is, provides an appropriate soil—is inflammatory action. This is seen when phthisis follows catarrhal inflammation of the pulmonary mucous membrane, when tuberculosis ensues close upon gonorrhœal epididymitis, and in which tuberculosis follows slight mechanical injury of the spine and the joints. It is equally clear that the tuberculous process advances while inflammatory action is in progress, and recedes when inflammatory action is arrested. This is seen in cases in which, as long as a joint affected with tuberculosis is disturbed by movement, the disease steadily advances, while as soon as the joint is kept at rest—provided the mischief is not too far advanced—the tubercular process loses its activity and gradually undergoes complete arrest.

But, I may be asked, what of the relapses which are so notoriously frequent in cases in which it was hoped that a cure had been effected? The question is an important one. Relapses are of two kinds. There is one which occurs when the patient is allowed to get about too soon—that is, before there has been time for (*a*) the arrest of the tuberculous process, (*b*) the removal of the tuberculous products, and (*c*) the return of the affected tissues to a sound condition. Now it is these consecutive changes which constitute recovery, and they are, it is obvious, of such a nature that they must necessarily occupy a considerable time. The period required, even in cases treated when they are quite incipient, can very seldom be less than from six to nine months; generally it extends to a year or a year and a half. In cases of longer standing, where an extensive deposit of tubercle has taken place, the time required for sound repair must be extended to two years or even more. When once suppuration has become profuse the time will be three or four years.

The other form of relapse is one which is, I think, often misunderstood. It occurs in cases in the treatment of which the necessary time has been given, and they are not relapses at all in the proper sense of the word, for they do not depend on any renewal of the tubercular process. The explanation of these so-called relapses is that the joints, damaged by the previous disease, but now quite free from tubercle, become, from overuse, the seat of an attack of common inflammation. It is as if a joint, damaged by injury or by rheumatism, should, when overtaxed, from time to time break down. That this is the true explanation is shown by the circumstance that if these patients are made to lie up for a month or six weeks, these false relapses, attended as they often are with severe pain, and perhaps with nocturnal startings of the limb, will completely subside, and leave the patient quite as well as he was before.

That infection from the joints is comparatively rare becomes evident when a sufficient number of cases are examined. This appears, if we turn to the statistics of the Alexandra Hospital for Hip Disease. The cases treated in this hospital, from its foundation in 1867 to 1879, were tabulated by a committee of the Clinical Society in 1880. From these tables it appears that in 260 suppurating cases in which no operation was performed there had been, at the time of the report, sixteen deaths (that is, 6.15 per cent.) from tubercular meningitis —in other words, as I suppose we may consider, from acute general tuberculosis, —and in 124 non-suppurating cases there

had been seven deaths (that is, 5.6 per cent.). A careful analysis of the cases treated in the hospital since 1879 shows that the mortality from general tuberculosis in suppurating cases has fallen to less than 5 per cent.

An estimate of the frequency of general infection may also be derived from Mr. Croft's 45 cases, and Mr. Wright's 100 cases of hip disease treated by excision, for in many of these the disease was well advanced before the operation was performed, and after the operation convalescence was in many retarded, or was never reached, so that the conditions favorable to general infection were present for a considerable period. In Mr. Croft's 45 cases the mortality from tubercular meningitis was only 4.4 per cent., while in Mr. Wright's series of 100 cases there was apparently only one case of acute general infection. From these figures it appears that, although the possibility of general infection from a tubercular joint is a distinct element of danger, the risk is so small that it cannot be regarded as affording any substantial support to the practice of early excision; for, let us grant that in every hundred cases of tubercular joint disease going on to caseation there are five in which systemic infection will occur, this means that in every twenty children one will fall a victim, and that the remaining nineteen will escape; or, to state it otherwise, that the chances of escape in any given case are twenty to one in the patient's favor. The question, therefore, is, are we justified in resorting to excision in twenty cases in order to rescue the one case in which general infection would otherwise occur? Are we justified in excising the joint of a patient, in order to avert the danger of general infection, when the chances that he will escape are already twenty to one in his favor? I believe we are not.

Thus, after carefully weighing the evidence we at present possess respecting the systemic infection from tubercular joints, I am led strongly to the conclusion that the number of cases in which it takes place is so limited that the prospect of its occurrence constitutes no valid reason for early excision; and this opinion is confirmed by the fact that there is no certainty that, after excision, there may not remain other tubercular centres, from which infection may still be developed, nor any certainty that the operation may not itself precipitate the result.

I will now return to the instance of hip disease. The treatment adopted has been that of prolonged rest in the horizontal position, combined with weight extension of the affected limb. This method, although of course it involves some important details, is, in principle, so simple and so well known that it is needless to describe it; but the method of dealing with suppuration claims more particular notice. All abscesses have been opened as soon as they have been detected. An incision from an inch to an inch and a half in length is made, matter is evacuated by gentle pressure, and a small drainage-tube, just long enough to enter the cavity, is used for two or three days. The dressing has consisted of carbolic gauze, next the wound, and this has been covered superficially with alembroth wool. The dressing is changed according to the case. In many instances the wound closes in a fortnight or three weeks, sometimes even sooner; in others it becomes a sinus, which discharges for a month or six weeks, and then heals; in others, again, suppuration remains free for several weeks, or even longer, and further openings have to be made; but at length, in a large majority of cases, the wound heals, and no further suppuration, except in a very few instances, takes place.

I am aware that the question whether abscesses should be opened at once is still under discussion. It is well known that, if left to burst spontaneously, they often do so quietly and without accession of fever or constitutional disturbance; but they have been opened in the cases I am alluding to (1) because, as abscesses which are connected with tubercular disease, and charged with tubercular material, it seems advisable that their contents should be evacuated as early as possible; (2) because, as experience amply shows, if left they frequently steadily enlarge, and lead to wide infection of the surrounding structures, and to the development of long devious sinuses, which become themselves lined with tubercular growth, and the seat of long-continued and exhausting suppuration, attended with the maintenance of a high temperature; (3) because, by the method of incision, draining, and careful dressing, these abscesses may be safely evacuated without the occurrence of those septic changes and their results—hectic, high temperature, and wasting which formerly were so liable to be met with—so

that the period, and also the dangers, of suppuration are very materially curtailed. It is true that such abscesses may be absorbed; indeed, their absorption, I believe, is more frequent than some observers might think; but this event is, after all, so rare that it ought not to be allowed to interfere with any general rule of practice. I am sure, from considerable experience with both methods, that evacuation by free incision and drainage is much to be preferred to aspiration; for although some abscesses, when once emptied by the aspirator, will never refill, this is not the case with the majority; the majority commonly fill up again every week or every fortnight, and at length have to be incised; while, in not a few, septic changes occur after aspiration, so that this method is certainly not materially, if it is at all, safer than the free incision I have described.

I must now state how the cases I propose to analyze, and which have been treated at the Alexandra Hospital, were obtained. The report of the committee of the Clinical Society, published in 1880, dealt with the cases that had been treated at this hospital between 1865 and 1879.

We went back to cases which had been discharged from the hospital for at least a year, and we then took the names in the order in which they stand in the admission book, and we worked backwards, towards 1879.

One hundred and sixty cases, which had been discharged for a year and upwards, were written to, and 76 came for inspection. Many cards were returned "gone away" or "not known" and to many there was no response. In no instance has a case which presented itself been excluded from the report, and in no instance in the 160 cards sent out, was a notice returned that the patient was dead. These 76, therefore, include every case, in the 160 written to, that could be traced.

Of these 76 patients, 37, or a little less than half, were cases which had suppurated, and 39, or a little more than half, had not suppurated. Among the 37, there were 2 cases of double disease, and in the 39 there was 1 double case. A careful examination showed the following results:

Of the 37 suppuration cases, only 4 still had sinuses. Of these sinuses all were single and quite small and superficial, and were discharging very slightly. As to the general result. We classified the cases under four headings: Perfect, excellent, good, moderate.

1 was a perfect recovery
6 were excellent
17 were good
} that is 24, a little under 65 per cent.

13 were moderate, a little over 35 per cent.

Period after Discharge.—When the examination was made, 7 had been discharged under 2, years, 9 between 2 and 3 years, 5 between 3 and 4 years, 16 over 4 years. So that sufficient time had elapsed to indicate what the ultimate result had been.

As to the Amount of Shortening of the Limb.—3 had no shortening, 17 had under an inch, 12 had between 1 and 2 inches, 3 had 2 inches or over; the average being 1 inch. Two were double cases.

As to Movement.—1 had perfect movement in every direction, 10 had free movement, 7 had slight movement: 50 per cent.; 18 were fixed: 50 per cent.; 1 was not noted.

As to Power of Walking.—2 walked perfectly, 22 walked well: 65 per cent.; 13 walked indifferently: 35 per cent.

Of the 39 non-suppurating cases (one being a double case) the general result was—9 perfect recoveries, 9 excellent recoveries, 12 good recoveries: 77 per cent.; 9 moderate: 23 per cent.

Period after Discharge.—14 had been discharged between 1 and 2 years; 5 between 2 and 3 years, 5 between 3 and 4 years, 10 over 4 years; 5 were not noted, but they had been discharged upwards of a year.

Amount of Shortening.—8 had no shortening, 19 had under 1 inch, 11 had over 1 inch (one a double case). Average two-thirds of an inch.

As to Movement.—9 had perfect movement, 10 had free movement: about 50 per cent.; 10 had slight movement, 10 were fixed: about 50 per cent.

As to Power of Walking.—12 walked perfectly, 20 walked well: 84 per cent.; 6 walked indifferently: 16 per cent.; 1 was not noted.

If we now take out the 33 cases which were admitted within nine months of the onset of the disease—the average duration being six months—we find that 16, that is about half, suppurated, and 17 did not suppurate. Of the 16 cases that suppurated (two were double) the general result was: 2 excellent, 5 good: not quite 50 per cent.; 9 moderate: a little more than 50 per cent.

As to Shortening of the Limb.—7 had under 1 inch, 4 between 1 and 2 inches, 1 was 2¼ inches, 1 was 3½ inches, 1 was 4 inches; 2 were double cases. Average shortening 1½ inches.

As to Movement.—5 had free movement, 4 had slight movement, 7 were fixed, 1 not noted; 1 was a double case.

As to Power of Walking.—11 walked well, 5 walked indifferently.

Of the 17 non-suppurating cases among the early admissions, the general result showed that 7 were perfect recoveries, 4 were excellent, 4 were good: 88 per cent.; 2 moderate: 12 per cent.

As to Shortening.—4 had no shortening; 7 under 1 inch, 5 between 1 and 2 inches, 1 a double case. Average shortening half an inch.

As to Movement.—5 had perfect movement, 5 had free movement, 2 had slight movement, 4 were fixed, 2 were not noted, 1 was a double case.

As to the Power of Walking.—7 were perfect, 9 walked well, 1 walked indifferently.

The average duration of the 37 cases of suppuration up to the time when all symptoms of the disease disappeared and the children were walking freely on the limb and without crutches—that is, until they were apparently finally cured—was a little under five years. In the non-suppurating cases it was just over three years.

If we turn to the question of mortality, we find that the number of instances in which death has occurred, so far as we could learn, as the result of the disease, in 614 cases that had been discharged since the beginning of 1880 (76 of the total number of 690 being still in the hospital) was 35. Of these 35 deaths the causes were as follows: Meningitis, 12; disease of lungs, 5; amyloid disease, 9; following amputation, 3; exhaustion, 2; uncertain, 4.

In 13 other instances in the total 614 cases the patients were apparently incurable when they were discharged, or when they were last seen, and in 4 cases amputation was performed. If these are added to the deaths we have 52 cases, that is, about 8.4 per cent., in which the treatment persued is known to have failed, wasting, has remained. In more advanced cases, though the period occupied is longer, the same treatment will lead to good repair. As the degree of repair that takes place is not apparently credited by the advocates of excision, I would point to the cases already related, and I may offer the following instance as a further illustration.

A. P., a girl aged seven, had had tubercular disease of both knees for more than twelve months. The joints presented a typical appearance, and were flexed and enlarged, the synovial membrane was pulpy, and the muscles of the thigh were much wasted. She wore leather splints for two years, and was kept entirely off her feet. Her general health remained perfectly good. As the degrees to which the joints could be extended increased, splints were renewed and straightened to a corresponding amount. At the end of two years all trace of the disease, except muscular atrophy (and this was not very marked), had entirely disappeared, and the movement of the joints was perfect. Two years later this patient was still quite well.

Many cases of a like degree of disease in the other joints could be given, but those I have related will be sufficient. Nor will time allow me to enter into details respecting caries of the spine; and I will only remark that my experience of this disease closely accords with what I have seen in the joints. When prolonged rest is secured, though these cases are tedious (for tubercle, when once deposited, cannot be got rid of quickly), there is nothing inveterate about them. They respond at once to treatment, and steadily improve; and in the great majority complete recovery, although often with some degree of deformity, takes place. They become unmanageable only when they have been allowed to advance for a twelvemonth and upwards before treatment is commenced.

In fact, it is with caries of the spine as it is with diseases of the joints. Early diagnosis and adequate treatment will lead to recovery; but if the process is allowed to advance month after month, or, as is sometimes the case, year after year, neither present nor future surgery will be able to bring about satisfactory results.

General tuberculosis occurs in some instances as the result of infection either from any of the joints, or from the spine. I have seen occasionally such cases. But I feel convinced that the percentage here is very much the same as that obtained in the majority of cases.

I believe it is now recognized by most surgeons that, although the immediate result of excision of the knee in children,

may be all that could be desired—the wound often healing by primary union, or at least very quickly—the ultimate result is unsatisfactory. The union between the bones gradually, in many instances, yields; the bones do grow imperfectly, deformity ensues, and the functions of the limb are materially interfered with. It will, I venture to think, be much the same in the case of the hip. The wound may heal by primary union, and the earlier the operation the more probable will this form of union be; but deformity will often ensue, and the limb in many cases will be weak and deficient in usefulness. In short, it will be seen in both cases alike—in the knee and in the hip—that when one of the principal joints of the lower extremity has been removed during childhood, the patient has been seriously crippled.

MISCELLANY.

White (J. W.) on the Toxic Action of Chromic Acid Used as a Cauterant.—My attention was called during October last to the case of a young woman, an inmate of the venereal wards, who had a mass of vegetations covering the labia majora and the nymphæ, extending up towards the pubes and down towards the anus, and several inches in thickness. This had been variously treated and had constantly recurred. I had been interested in trying the simple treatment recommended by Dr. Peters, of Prague, consisting in the application of cold poultices, a method indorsed by Zeissl and by Bumstead, who mention cases in which very extensive vegetations disappear under the simple use of water-dressings. The patient, an otherwise healthy girl, was placed upon this treatment, which was continued for about two weeks, at the end of which time my resident reported to me that there had been absolutely no improvement. I then ordered the usual application of chromic-acid solution, of the strength of one hundred grains to the ounce of water, directing him to protect the neighboring parts and to avoid using an excess of the acid. The application was made on the afternoon of the same day. The acid solution was applied by means of a tuft of absorbent cotton, about a half-ounce of the liquid being used. The vagina and anus were carefully protected by tampons of cotton soaked in carbolized oil. After coming from under the anæsthetic she complained of a burning pain referred to her vulva; this continued through the night, during which time she was restless and frequently called for water. About 4 A.M. she rose to urinate, and fell; she was assisted to bed and slept until 7 A.M. She continued thirsty but not feverish all the morning, complained of nausea, and refused her food. When next seen, at 3 P.M., she was pale, with cold extremities, rapid pulse, complained of pain in the left hypochondriac region, and expressed fear of approaching death. Temperature in axilla 99°. Although active treatment was instituted her condition did not improve, and she died at 6.30 P.M., twenty-seven hours after the application of the acid. Intellection was preserved to the last.

A careful autopsy was made with the following results: *Body*, that of a well-nourished, medium-sized girl; marked post-mortem discoloration on the back of trunk and limbs. Small scar on left thigh. Mass of venereal warts at vaginal outlet, occupying both labia and extending from anterior commissure to anus; dark in color and covered with an offensive discharge. *Thorax*.—Both lungs crepitant throughout; some hypostatic congestion posteriorly. The left lung adherent to the chest wall posteriorly, and to the diaphragm. Right lung free. Pericardium contained about two drachms of clear straw-colored fluid. *Heart*.—Right auricle filled with currant-jelly clot. Small chicken-fat clot in left ventricle. Auriculo-ventricular and semilunar valves perfectly normal. *Abdomen*.—Stomach distended, mucous surface shows numerous fine ecchymoses, the result of vomiting. Section of duodenum shows biliary ducts patulous. Large intestine distended with gas, and containing fecal matter. Liver small, weight 40 oz.; on section shows the nutmeg change. Gall bladder distended, with a very dark-colored secretion. Spleen flabby, pale; weight 5 oz. Kidneys the seat of passive congestion. small, weight 9 oz. Capsules strip off easily. *Vagina*.—Section of vagina shows mucous membrane dark-red in color, covered with a yellowish discharge, with no evidences of contact of acid. *Brain*.—Dura thin, non-adherent, longitudinal sinus contains post-mortem clot. Veins of pia mater swollen and congested. Puncta vasculosa large. Choroid plexus injected.

Portions of the various viscera were submitted to Dr. John Marshall for analysis, who reported as follows :

"The kidney tissue and the liver tissue both contained chromium, most likely as sodium chromate—a substance poisonous in doses of from one to three grains. The tissue of the rectus muscle was free from chromium. The chromic acid was absorbed, and entered into combination with the sodium of the sodium carbonate of the blood to form sodium chromate. This is the most probable explanation of what occurred."—*University Med. Mag.*, Nov., 1889.

Moorehead (J.) on Arthritic Hæmoptysis.—Several years ago I was summoned to attend a gentleman, about eighty years old, who, after having had a sail in an open boat during an easterly wind, was suddenly seized with copious hæmoptysis, associated with bronchitic symptoms. There was no evidence of cardiac disease, of thoracic aneurism, or of tuberculosis. As the breathing was considerably embarrassed, saline aperients with diaphoretics were prescribed.

At my next visit, on the following day, I was agreeably surprised to find the hemorrhage had entirely ceased, but that an acute attack of gout had supervened in the right foot. Under the usual alkaline treatment the podagra speedily disappeared, the recovery being complete. It seems to be clearly gouty hæmoptysis due to thrombosis of the terminal blood-vessels of the lungs.—*Br. Med. Jour.*, Nov. 2, 1889.

Cree (W. J.) on Salol and Bismuth in Diarrhœa.—Lately I have been using salol and bismuth in intestinal troubles with excellent results. The first case was one of diarrhœa in an adult, with intense pain and vomiting. Salol, gr. v., bismuth subnitrate, gr. x., was ordered every two hours. After the first powder was taken there was no vomiting, and after the second no pain. The powders were then taken every four hours, resulting in a speedy cure.

Six cases in adults have been treated successfully in this manner.

In cholera infantum, salol and bismuth has been used in four cases, with one death. This child, aged five months, was brought to me on the fourth day of illness, with a history of from fifteen to twenty passages daily, and almost incessant vomiting. I had very little hope for the child, yet the vomiting was relieved to a great extent. Brain complications soon appeared and the child died.

In the other forms of diarrhœa in children, about twenty cases have been treated with salol and bismuth, with good results. The vomiting when present was kept under control, the number of passages quickly diminished, with relief from pain, and loss of odor of the discharges. In some cases the addition of pulv. ipecac et opii was called for, in others pepsinum purum (P., D. & Co.'s); again, ext. ergot. fld. was given, but in the larger number of cases, salol and bismuth alone was given.

The quantity of salol was : gr. ½ to gr. ij. for a child, gr. iij. to gr. vj. for an adult; bismuth subnit., gr. j. to gr. iv. for a child, gr. v. to gr. xv. for an adult. I have not mentioned bathing, hot and cold applications, and the general treatment pursued in such cases, but briefly report my experience with the above remedies.—*Am. Lancet*, November, 1889.

Duke (A.) on Hot-Water Operating Tables.—Now that the winter has come, may I suggest, as a means of comfort to suffering patients in hospitals, while undergoing operation, and subsequently while recovering from the collapse so common after prolonged anæsthesia, the use of a hot-water operation table covered with blanket. The top of any table could be made double-formed of zinc or tin, and filled with boiling water before operation, thus maintaining the natural temperature of the patient, adding greatly to his comfort, and preventing subsequent shock. A table so constructed would be far preferable to the ordinary hot-water bottle applied at random, often too hot, and sometimes so removed from the patient as to be of no use whatever.

I shall feel much pleased if my suggestion is adopted by some of the hospitals, as I feel sure it will be appreciated both by doctor and patient, saving the former anxiety and trouble, and the latter a vast amount of unnecessary discomfort, if not actual suffering.—*Med. Press*, November 6, 1889.

West (J. A.) on Sulphonal as an Analgesic.—The patient is a young man, always of delicate health, who suffers frequently from intense vertex headache, described as being sometimes accompanied by "a numb feeling, and sometimes sharp, acute pain, like knives cutting." I prescribed a draught containing 20 grains of

sulphonal, as he had been almost entirely sleepless for several nights in consequence of the pain. The patient's home being in the country, I was not able to watch the case, but, writing for information as to the result of the draught, I received the following reply from a friend with whom he had been staying: "He generally has a draught by him of a night, and when that fearful pain comes on, takes it. It has never failed yet to send him to sleep, although the time before it takes effect varies a little according to the intensity of his pain; sometimes he will sleep right on till morning after it, but sometimes the pain rouses him again for a time during the night. The draught is certainly a great blessing to him and to me, as I can leave him when he is with us without thinking that he is moaning with pain half the night; he is generally fairly free next morning too."—*Br. Med. Jour.*, Nov. 2, 1889.

Salt and Microbes.—A foreign observer has carried out some instructive researches into the effect of salt on various pathogenic micro-organisms. He found that the results varied a good deal, according to the particular microbe experimented upon. The cholera bacillus, for example, curled up and died in a few hours, while the bacillus of typhoid fever and the micrococci of pus and erysipelas resisted its influence for weeks and even months. That part of his observations bearing on tuberculosis possesses a practical importance, owing to the custom in slaughter-houses of salting the flesh of animals recognized to be tuberculous, and exposing it for sale in the course of a few weeks. M. de Freytag has shown that the tubercle bacillus thrives in the presence of an excess of salt, and salting the tuberculous tissues of an ox in no wise prevented the infection of animals fed thereon. Hence it is highly desirable that a stop should be put to a practice which exposes those who partake of the diseased meat to such obvious risks of infection.—*Med. Press*, Nov. 6, 1889.

Cant (W. E.) on a Case of Keratitis from Paralysis of the Fifth Nerve.—The patient, a lad aged sixteen, attended the hospital, on July 17, 1888, with complete paralysis of the left fifth nerve. The left eye showed some general injection, and the cornea was diffusely hazy. A history was obtained of an injury by a reaping-hook two or three weeks previously, and a doctor who saw the lad two days after the blow had been inflicted found him in a semi-conscious state. There was a small penetrating wound of the squamous portion of the left temporal bone, about an inch above the insertion of the auricle; into this wound a probe could be passed to the depth of rather more than one inch. When seen again on July 22d, the left cornea was quite opaque, of a milky-white color; there was much general congestion of the eye. He was admitted to the hospital. During the next three weeks the condition of the left cornea became rather worse, and marginal ulceration occurred. The paralysis of the fifth nerve remained complete. The patient then left the hospital, and was not seen again for four months. When he returned, the left cornea had partially recovered, but was still generally hazy. The function of the fifth nerve, both muscular and sensory branches, had been regained, but to only a limited degree. Mr. Cant thought the case had been one of direct injury to the whole fifth nerve within the skull, between the brain and the Gasserian ganglion, or at the latter.—*Lancet*, Oct. 26, 1889.

Edson (C.) on Disinfection of Dwellings by Sulphur Dioxide.—An extended experience in the use of this fumigant has led to the belief that it is a thorough and almost perfect destroyer of the infection of the acute exanthemata and diphtheria. The evidence, however, is mainly circumstantial. Statistics were quoted from the records of the Health Department to show the non-occurrence of disease where premises had been fumigated by this agent.—*Med. Record*, Nov. 2, 1889.

Walker (J. O.) on the Treatment of Dysentery.—In three and one half months the author has treated ninety-three cases of dysentery. In eighteen cases he carried out the usual line of treatment, opium by mouth and rectum, acetate of lead, and other familiar astringents. Of the cases so treated two died. The other cases were treated as follows:

If called before the process of disintegration begins, he gives sulphate magnesia combined with dilute sulphuric acid; it empties the bowels of all irritating matter, relieves congestion, and afterwards acts as an astringent.

If the disease continue after the action of the above, he instructs the nurse, if she possesses ordinary intelligence, how to use the hypodermic syringe, and has her inject

in patient's arm, if he is an adult, ⅛ gr. sulph. morphine and 1-200 gr. sulph. atropine every four or five hours, if bowels move too often, or if suffering much pain.

To act upon the diseased mucous membrane, nothing is better than the sulphocarbonate of zinc; it is a splendid antiseptic and an astringent of much value. If patient suffers much from tenesmus, he introduces into the rectum a soft-rubber tube, and by means of a fountain syringe injects into the bowel one quart of very warm water, to which some antiseptic has been added, such as salicylate of soda, 10 grs. to O. This is done every three or four hours, if necessary, and it rarely fails to give complete relief. If the abdomen becomes very sore and tympanitic, turpentine liniment is applied on flannel to abdomen as often as necessary. To counteract depression, he gives milk punch, French brandy, eggnog. Such articles of food as peptonized milk and the juice of meat are excellent.

He has followed this line of treatment in 76 cases, and is gratified at the result.

He lays especial stress upon the free use of morphine and atropine, accomplished by the co-operation of the nurse.—*North Carolina Med. Jour.*, Oct., 1889.

Cooling of the Body by Spray.—Dr. S. Placzek, following up some laboratory experiments by Preyer and Flashaar, on the effect of spraying a considerable part of the body surface of animals with cold water, has applied the spray for the purpose of reducing febrile temperatures in human beings. In the case of a man suffering from phthisis, whose temperature was high, he found that by spraying about a pint of water at between 60° and 70° F. over his body the temperature fell to normal, and continued so for several hours. Again, a similar method was satisfactorily applied in the case of a girl with diphtheria. In the healthy human subject the spray lowered the temperature nearly 2°, and in animals which had been put into a condition of septic pyrexia by injections of bacteria, the temperature was reduced to normal by the spray. By keeping healthy guinea-pigs and rabbits some hours under spray and using from half a pint to a pint of water at the temperature of the room—44° to 62°—the temperature of the animals fell several degrees.—*Lancet*, Nov. 9, 1889.

Oliver (T.) on the Analytical and Clinical Examination of Lead Poisoning in its Acute Manifestations.—The author showed the prevalence of poisoning by lead at Newcastle-upon-Tyne, the home of the lead trade. It was more common in women than in men. Of 135 patients admitted into the Newcastle Infirmary, eight died of acute manifestations; of these, five were females. A rapidly increasing anæmia was one of the earliest symptoms, and it was followed by colic, headache, vomiting, and diplopia or defective vision. In a few days the patient might become convulsed, comatose, and die. The illness might be so rapid that no alterations of the viscera could be found after death, other than a hydræmic condition of the brain. The author discussed the cause of the anæmia in lead poisoning, of the defective vision, and of the brain symptoms, and gave the results of analysis of the urine. Though the kidneys were contracted in nearly all chronic cases, gout was practically unknown among the lead workers in Newcastle-upon-Tyne.—*Lancet*, Oct. 26, 1889.

Porcine Pneumo-Enteritis and Human Enteric Fever.—A farmer, R. G., his wife, daughter, four sons, and one other person—seven in all—resided in a small cottage at the outskirts of Hendon. Upon the farm were kept thirteen cows and about one hundred pigs. The milk from these cows was mainly disposed of directly to customers in Hendon, being delivered to them by Mrs. G. and one of the sons. Part of it was also sold in a shop in Hendon. The cottage consisted of a small kitchen, two bedrooms, and a dairy, all opening off each other on the same floor. The dairy, which could be entered from the bedroom, had also a separate entrance from outside. The rooms were ill-ventilated, and, considering the number of occupants, very small. The cows were kept in a stable about one hundred feet feet from the cottage, and after every milking the milk was taken to the dairy and measured before being sent out, any that was left over being stored in the dairy. The first case of typhoid fever occurred in one of the sons, a boy aged nine, who was taken ill on August 5th; he was nursed at home by his mother. The next case was an older son, who slept with the boy; this young man took to his bed on August 26th: the farmer himself and another son took to their beds on September 4th, the mother on September 9th, and the daughter, who had been nursing the

other patients, on September 17th. Eleven cases occurred among consumers of the milk in Hendon between September 17th and 24th; one case had commenced a week or ten days earlier. Between September 26th and September 30th six other cases occurred among the customers of the dairy. As the distribution of the milk was stopped on September 12th, and as no cases beyond those enumerated above are known to have occurred, it may be reasonably hoped that the epidemic is now at an end. The evidence as to how the milk became contaminated is not perfectly clear. There was a surface well undoubtedly liable to pollution, but it was most positively stated that no water was used from it after August 1st, a stand pipe on the West Middlesex Water Mains having been erected for the use of the farm, and water drawn from it after that date. Dr. J. Cameron, the medical officer of health from whose report we draw these particulars, is able to state that no case of typhoid fever had occurred on this farm for many years previously. The family could not have been infected by sewer gas from drains, because no drains existed on the premises. The first case, the boy, aged nine, sickened on August 5th, and must, therefore, have been infected about the third week in July, but there is no evidence that the well water could possibly have become infected by the specific poison of typhoid fever from any human source either then or earlier. Dr. Cameron's attention was, therefore, directed to the animals on the farm; careful inspection of the cows showed that they were all in good health, but it was ascertained that upwards of eighty pigs had suffered from swine fever for about a month or six weeks, the last of them having been killed and buried on August 8th. The boy who first contracted the disease was constantly with his father amongst the pigs which were ill, watching the treatment, and assisting to bury the animals which died. So far as his movements could be traced, the only persons with whom he had come into contact beyond those living on the farm were some boys who lived in a gypsy van, and it seems to be certain that none of the inmates of the van had been ill during the summer. The farmer's family had consumed some pork of an apparently healthy animal during the prevalence of the swine fever. It would be rash to attempt to draw any definite conclusions at present from the facts of this epidemic, but the suspicion that swine fever or contagious pneumo-enteritis may be identical with human enteric fever is not entirely novel.—*Br. Med. Four.*, Oct. 26, 1889.

Antifebrin in Sore-Throat.—Dr. W. Sahli, of Langenthal, highly recommends the internal use of antifebrin, in the dose of from 0.25 to 0.5 gramme three times a day, in diphtheria and in scarlatinal and other forms of sore-throat. The drug has not any marked influence on the course of the disease, but it rapidly (in about a quarter of an hour) and completely removes such subjective symptoms as painful swallowing and mastication, faucial soreness, headache, etc. It may be given either in powder or in a mixture with alcohol and syrup. The latter form is especially useful in children. No disagreeable accessory symptoms were ever observed.—*Brit. Med. Four.*, Oct. 19, 1889.

West on Diabetes Mellitus Associated with Addison's Disease.—The patient, a man aged forty-nine, had been suffering from diabetes for six months, and he had lost 4 st. in weight. The urine contained 2.5 per cent. of sugar, and had a specific gravity of 1,034, with a trace of albumen. There was slight dulness at the bases of both lungs. The liver was large, and painful on palpation. The skin was of a grayish cyanotic hue. After admission the patient complained of scalding pain on micturition, with dysuria due to cystitis, and this caused a slight rise in temperature. The patient was dieted, and placed on a twelfth of a grain of pilocarpin night and morning, with an occasional dose of opium, which produced improvement in the diabetic condition. After a month's observation, an attack of subacute rheumatism developed, the temperature rose to 105° F., and the patient died, vomiting being a troublesome symptom. The supra-renal capsules were found at the necropsy to be imbedded in dense fibrous tissue, by which they were bound to the kidney on each side and to the other parts in the neighborhood. On microscopical examination, they showed no trace whatever of supra-renal structure; nothing but connective tissue, richly supplied with blood-vessels, remained. He regarded the association of diabetes with Addison's disease as nothing more than an accidental coincidence.—*Lancet*, Nov. 9, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLE.

Lister (J.) on a New Antiseptic Dressing.—Five years ago the author had shown not only that corrosive sublimate formed a compound with albumen in which the properties of the former were preserved, but that this compound, even after drying, was capable of dissolving in blood serum. Hence came the sero-sublimate gauze, which had a definite and admitted value. But certain defects soon revealed themselves in the gauze, which was somewhat harsh and not very absorbent. So the investigator pushed on, and sought for new agents. The first that offered was substantially the double chloride of mercury and ammonium, called sal alembroth. This presented great advantages; it was a better antiseptic, and at the same time was less irritating than corrosive sublimate. But again objections turned up, for the compound was so soluble, not only in water but in serum, that when the discharge was considerable, too much of the mercurial compound got to the edge of the dressing, and great irritation was caused. So another start was made with cyanide of mercury. This was found to be, in the author's language, high as to inhibitory, but low in germicidal, power. But it was irritating as well as very soluble, and the double cyanides—of which, without counting such bodies as the ferrocyanides, there are many—were next tried. Mr. Martindale suggested one of the insoluble double cyanides of mercury and zinc; such a compound has proved superior to all other substances hitherto used. There are several of these double cyanides, and there seems indeed some doubt as to the precise compound which exists in the preparation which is now used; but it is certain that the mercury in it is an important, though not in quantity a large, factor. The very ingenious method by which, after many trials, the substance was incorporated with starch, with which it forms a kind of combination whereby it can be affixed to gauze so neatly that in the dry state it does not become detached, and in the wet state does not wash away, and the apparently perfect success of the gauze, which is at once antiseptic, porous, permanent, and non-irritating, the author describes in detail, and we need only here refer to it.

But even the zinc mercury cyanide was not immediately successful, and some early difficulties caused it to be for a time abandoned. Then the patient investigator turned his attention to iodide of mercury. This is known to have antiseptic powers, and is besides very sparingly soluble in water. It is more soluble in blood serum, but then it is very irritating and difficult to fix to the gauze. The latter objection was removed by the employment of starch, then tried for the first time. Here, as with the double cyanide, a loose kind of molecular combination seems to take place, and the iodide does not dust off. But still the experimenter was not satisfied, and therefore, with the experience gained from the

starch experiments, fell back on the double cyanide, with which, under carefully prescribed conditions, he is for the present contented.—*Lancet*, Nov. 16, 1889.

MEDICINE AND PATHOLOGY.

Gillette (L. B.) on a Case of Brain Abscess Emptying into the Naso-Pharynx. — The patient, aged twenty, farmer by occupation, strong and healthy, while working on an embankment in September last with a wheel-scraper, in driving along with it loaded, it in some way became unlatched and the handle, in flying up, struck him forcibly under the chin, knocking him sixteen feet down an embankment, where he lay unconscious for thirty minutes. A week afterward he noticed that something was wrong with his eyes. About October 15th he went to work in a brick-yard, worked three days, and then complained of being nervous and of having a slight headache. On the evening of the third day he got soaking wet in a rain, went home cold, had a chill, followed by fever. A physician who was called pronounced it malarial fever. Dr. Gillette, being subsequently called to see the case, found the patient suffering with intense headache, the pain extending down between the shoulder-blades, and particularly into the right arm. Both pupils were widely dilated. Temperature was 101° F.; pulse, 105. He knew he had an inflammatory condition to deal with. A day or two later the patient began to manifest marked symptoms of compression of the brain. Temperature went down to 96°; pulse as low as 42; respiration to 9 or 10. Complete paralysis of right side and partial of left; complete loss of sensibility as well as of consciousness. He also lost the sense of sight, and remained in this condition four days without any perceptible change whatever. The patient took his food and medicine regularly. Dr. G. was surprised one morning to find that the patient had much improved. The mother told him that during the night the patient had a violent attack of coughing and showed him the character of the sputum. It was about an ounce of green, stinking pus, mixed with mucus. From this time the patient began to improve. There was an immediate return of consciousness, a quickening of the heart's action and respirations. Examination of the throat showed that the pus came from above. No pus came out of the Eustachian orifices, and when the patient leaned forward it would come out of the anterior nares. The discharge lasted two weeks. Where it came from, or how it came, the author could not tell. His opinion favored the ethmoidal and sphenoidal sinuses. As a result of this terrible ordeal the patient, when seen three months since, was totally blind, sense of hearing lost in right ear, has not got the use of his right arm, and his mind is not what it was. The author asks, Could such results take place without some destruction of the brain-tissue proper? Could the patient have the same results from an intra-meningeal accumulation?

In the treatment Dr. Gillette used opium, quinine, mercury, cold applications to head, and cupping at the back of the neck, and the triple bromides as they were indicated. As soon as marked compression of the brain had developed he began to use eighty grains of iodide of potash each day, and kept it up for thirty days.—*Med. Record*, Nov. 23, 1889.

Locq on the Infectious Origin of Tetanus Neonatorum.—An otherwise healthy child died on the tenth day of tetanus. Within 150 paces of the house was a stable which contained horses which had been in contact with a tetanic horse. The mother of the child hung the family washing to dry in this stable and it was thought that the dust of this stable would prove infectious, but it was carefully experimented with and found harmless. M. Locq inoculated some guinea-pigs with mud and dirt procured near the house, and they died on the fourth day of tetanus. From the pus of these animals he isolated and cultivated bacilli, which when inoculated killed healthy guinea-pigs in the same way. Inoculations made with the spinal cords of the animals resulted negatively.—*La France Méd.*, Nov. 9, 1889.

Syphilitic Contagion in the Tertiary Stage.—Laudouzy cites two examples of this condition. A man in the fifth year of syphilis, having at the time no active symptoms whatever, communicated the disease to his wife. In the other instance a man with a gumma of the penis gave his wife syphilis. Balzer claims that mucous patches can develop at almost any stage of syphilis, and that their presence, perhaps overlooked,

explains these cases of irregular infection. —*La Tribune Méd.*, Oct. 10, 1889.

Robinson (W.) on Recurrent Chancre.—Mr. H. contracted a chancre early in 1888, and was treated for it by a London surgeon, who mercurialized him to salivation, applied nitric acid several times to the sore, and gave the patient lunar caustic to touch it with. The seat of the sore was at the free edge of the prepuce, on the dorsal aspect, half an inch to the right of the median line. He had also congenital phimosis.

In June of the same year he consulted me. He was then anæmic, had lost much flesh, had sore-throat and severe pain in the limbs, and his hair was falling out; there was no rash on the skin. At the site of the sore was a slight cicatrix, and in the left groin a gland was enlarged and threatened to suppurate. He was told to rest, given mercury in small doses, and glycerinum belladonnæ to paint over the gland, which, however, suppurated, but soon healed. He improved rapidly under treatment and was soon well. He was recommended to continue the mercury for at least six months, which he did, leaving it off at Christmas, when he felt quite well. In January, 1889, a large abscess formed in the left groin, which burst and healed; being in the south, I did not see him at this time. Soon after this a sore began to form exactly on the site of the old one. In March he came to me again, when the sore was found to be a raised and well-defined induration, ulcerated on the smooth surface and secreting a thin watery discharge. An enlarged and hard gland was in the right groin. Mercury internally and the usual applications did no good, doubtless owing to the stretching of the phimosed prepuce at each act of micturition and the irritation of the urine. He felt quite well, and had no other symptoms. Circumcision at once removed the "recurrent" chancre, and cured him of his phimosis. That the second sore was not due to a fresh infection is proved by his absolute denial of fresh exposure, and to the fact of its not being followed by any other symptoms of syphilis. — *Lancet*, Nov. 2, 1889.

Syphilis of Extra-Genital Origin.—Lancereaux reports two very interesting cases of syphilis acquired by the use of unclean instruments.

A man of fifty-three had a Eustachian catheter passed on September 13th, and again early in November, causing a bloody discharge. Secondary symptoms appeared in December.

In the second case, a woman of thirty-six, the removal of several teeth and the insertion of a set of false teeth on the upper jaw, in some way, inoculated the patient, who developed a chancre on the upper lip, which was duly followed by secondary symptoms.

Three other observers cited cases where inoculation followed the use of the razor.—*L'Union Méd.*, Nov. 7, 1889.

Legay on Lesions Secondary to Cancer of the Uterus.—The kidneys, heart, and liver are the organs most likely to be diseased in cancer of the uterus. The ureters are compressed and distended, the urine backs up into the kidneys, the convoluted tubules and capsules of Bowman are distended, the epithelium is flattened, and the entire organ made anæmic. This ascending nephritis is rarely accompanied by ventricular hypertrophy and when it does occur it is generally found that the subject is alcoholic.

The fatty degeneration of the liver, so frequent in uterine epithelioma, is explained b auto-intoxication, recent experiments showing that an important function of the liver is to destroy poisons, and that certain toxic agents bring about a very rapid fatty degeneration of the hepatic cells.—*Rev. Méd-Chir. des Mal. des Femmes*, October 25, 1889.

Troisier on Pneumothorax Coming on during an Attack of Asthma; Puncture and Cure. — A woman of twenty-seven had had frequent attacks of asthma since the age of nineteen. In June, 1887, she had two violent attacks without apparent complication, the temperature being 105° F., the pulse small and rapid.

July 1st she presented all the signs of a left pneumothorax, which had come on insidiously without pain or dyspnœa. The next day her chest was punctured, about five pints of air escaping, and attacks of coughing and mucous expectoration came on, which stopped in a few hours; complete absorption of the air remaining after the puncture took place. No pleurisy was excited. — *La France Méd.*, October 29, 1889.

Arloing on the Microbe of the Contagious Pleuro-Pneumonia of Cattle. —The author has discovered four different microbes in the diseased organs in pleuro-

pneumonia. He believes that the one he designates as the *pneumo-bacillus liquefaciens bovis* is the pathogenic microbe of the disease for the following reasons :

1. That this microbe is always found in all the diseased lungs and in the metastatic synovites which sometimes result from inoculation of pulmonary discharges under the skin ;

2. That intravenous injections of large amounts of a culture of the pneumo-bacillus, reinforced by a previous stay under the skin, develop the pulmonary disease with great rapidity ;

3. That when this culture is deeply injected it produces an affection in the muscular masses similar to that in the inter-lobular areas in the lungs, in the midst of which numerous cultures of the pathogenic microbe develop.—*Gaz. Hebd. des Sci. Méd. de Montpellier*, Oct. 5, 1889.

Daremberg on Tuberculosis Vaccine.—M. Daremberg has made a series of experiments on the lower animals which inspire him with the hope of eventually obtaining a prophylactic vaccine for tuberculosis. He observed, during his researches, that oil or fatty substances given to the animals under experiment enables them to resist the tubercular infection when the virus is inoculated under the skin ; glycogen had the opposite effect. When the virus is passed directly into the blood death is inevitable. Cod-liver oil is only useful when the entire organism is not infected by the tubercular virus ; it is a protective agent, not a curative. In all forms of phthisis strengthening food and tonics help the economy to withstand the influence of the poisons formed in the stomach and intestines by abnormal ferments ; they also facilitate the elimination by the kidneys, skin, etc., of the poisons resulting from defective nutrition found in the cells of different organs. The evolution of tuberculosis can in some animals be rendered slower by gradually accustoming them to the influence of tubercular virus, inoculating under the skin a small quantity of sterile tuberculosis cultivation before inoculating the deadly one ; spinal medulla removed from an animal dead of phthisis reduced to a pulp, and used for inoculation has also this effect. M. Daremberg concludes from these researches that tubercula virus can be treated like mineral or organic poison ; it can be increased or decreased ; also that the animal economy can be protected more or less against the action of tubercular virus. With these data acquired he foresees the day when he will transform tubercular virus into tubercular vaccine.—*Br. Med. Jour.*, Nov. 9, 1889.

Bouchard on the Rôle and Mechanism of the Local Lesion in Infectious Diseases.—The author after numerous new experiments concludes that the healthy body can victoriously repel the invasion of microbes and become refractory to contagious disease, possessing, in fact, immunity. In an abnormal or debilitated organism, however, microbes find a soil suited to their development. Between the two states there is every grade of receptivity. Among his proofs he cites Charrin and Roger as stating that pyocyanic bacilli do not proliferate in serum from a healthy animal, but multiply with varying rapidity in serum from a diseased animal.—*Le Courrier Méd.*, Nov. 9, 1889.

Nicaise on Subacute Cervical Adenitis of Intestinal Origin.—A woman, during convalescence from a severe enteritis, developed a tumefaction of the neck which lasted three months. It consisted of two or three movable and indistinct glandular swellings. One gave a sense of fluctuation and was opened, healing in five days. The author attributes the ganglionic enlargement to the enteritis, as he knew a case of cervical adenitis in which intestinal microbes were found. This is not strange, as we know that the cervical glands are often enlarged in carcinomatous disease within the abdomen.—*Le Courrier Médical*, Oct. 5, 1889.

Menzies (J.) on a Case of Scarlet Fever Complicated by Measles during the Stage of Desquamation.—On September 2d I was called to see A. B., aged ten years, suffering from sore-throat and other symptoms indicative of scarlet-fever, my diagnosis being confirmed by the presence of the usual scarlatinal rash, which was followed in a few days by desquamation of the cuticle. The case progressed favorably until September 13th, when my attention was directed to a second copious eruption, " flea-bite " in character, appearing first on the face and forehead, afterwards extending, and accompanied by catarrhal symptoms, leaving no doubt as to its being measles. Thirty-six hours from the appearance of the second eruption the patient sank into a typhoid state and died. —*Br. Med. Jour.*, Nov. 9, 1889.

Gibier (P.) on the Vitality of Trichinæ.—The author's experiments have chiefly to do with the resistance of trichinæ to cold. The experiments were conducted upon hams cured in sea-salt and saltpetre. He finds that the trichinæ in cured meat can withstand a temperature several degrees below freezing for about an hour. In fresh meat, however, a temperature of 45° Fahrenheit below freezing, or 13° below zero, continued for two hours, has not sufficed, to kill trichinæ.—*Le Courrier Médical*, Oct. 5, 1889.

OBSTETRICS.

Cordell (E. F.) on the Prevention and Arrest of Puerperal Mastitis and Abscess by Methodical Frictions.—The method of treatment of puerperal mastitis by frictions seems to the author to commend itself not only upon rational grounds, but also by the results of experience. The accessibility of the glands and the anatomical arrangement of the ducts, converging, as they do, from the periphery towards a common centre, and from smaller tubes to larger, enables us to employ pressure with the very best effect. By softening the clots and propelling onward the stagnant and fermenting milk, the pressure, irritation, and pain are relieved, and the subsequent excretion of the retained material is assured. Furthermore, this material is propelled in a direction by which alone its removal can be effected. Again, by getting rid of it, either by the natural method of suckling, or by artificial means, we empty the overloaded ducts, we remove pressure upon the blood-vessels and nerves, diminish vascular engorgement, and undoubtedly favor the proper secreting functions of the organ. And, finally, if it be true that micro-organisms are at the bottom of the morbid process, the best means for eliminating or getting rid of these is by thus depleting the organ by the channels provided by nature. Clinical experience offers still stronger proofs of the value of this method. Since the writer began the use of frictions, sixteen or eighteen years ago, he has not seen a single case of parenchymatous abscess, and only one small subcutaneous collection of pus, whilst during previous years he had several very painful and protracted cases, involving great suffering and helplessness, and demanding deep incisions. The author does not dispense with any additional measures that seem useful in aiding restoration and alleviating discomfort. He enjoins complete rest, and support by means of a handkerchief tied over the opposite shoulder. Suitable saline cathartics and anodynes may be demanded. Affections of the nipple demand appropriate applications and the utmost cleanliness.—*Med. News*, Aug. 31, 1889.

Pinzoni (of Bologna) on Ergot in Childbed.—The drug was administered, generally in the form of about two grammes of the powder daily, to ninety-one lying-in patients. Seventy-nine similar cases were treated without ergot. After comparing the series, the author came to the following conclusions: Ergot has little or no influence on the temperature; at the most a slight rise is occasionally observed. It hastens the pulse a little, yet has no marked influence on the physiological slackening of the pulse observed during the first days after delivery. The involution of the uterus, according to the author's researches, is either totally uninfluenced by ergot or slightly retarded. The escape of the lochia remains normal when the drug is given; but clots are more readily expelled. The lochia are seldom fœtid when ergot is taken. Ergot delays the after-pains in primiparæ and lessens them when they have already commenced. The secretion of milk is retarded and lessened by ergot, and sometimes completely suppressed. Ergot seems, according to Dr. Pinzoni to be a prophylactic against puerperal fever, an indirect antiseptic agent. When infection had taken place, ergot appeared, on the other hand, to hasten the entrance of the virus into the circulation. —*Br. Med. Jour.*, Aug. 10, 1889.

Haven (G.) on a Case of Tubal Pregnancy; Operation, Recovery.—The patient, nine weeks after her last menstruation, was seized with labor pains and passed a mass about the size of a pear. At this time, on examination, it was found that Douglas' fossa was filled by a mass of uncertain shape, which extended towards the right side. The uterus was pushed forward, felt large, but was freely movable. Laparotomy was advised, and a few days later the abdomen was opened. The peritoneum was thickened by old inflammation. The mass was easily felt on the right side, and was adherent to the sides of the pelvis,

with adhesions running in all directions. It seemed at first an almost hopeless task to find it; but after considerable manipulation, it was brought outside the abdomen. The microscopical examination showed that the mass in the tube at the place of its insertion had choroinic villi, thereby settling the diagnosis of tubal pregnancy. —*Boston Med. and Surg. Jour.*, Aug. 15, 1889. E. S. B.

THERAPEUTICS.

Sèe (G.) on Iodide of Potassium as a Cardiac Tonic.—The author has found that the iodides of potassium and sodium have very different actions and cannot be substituted one for the other. The potassium, does while the sodium does not, act on the heart and vessels. If from 15 to 45 grains of the iodide of potassium are injected into the veins of a dog, there is noticed first an *alkaline period*, in which the pulse becomes rapid and the arterial tension is raised; and second, an *iodic period*, during which the arterial pressure diminishes; with the iodide of sodium there is no alkaline period. In the alkaline stage there is constriction of the vessels, while in the iodic stage there is vascular dilatation. The potassium salt is, then, with digitalis, a permanent cardiac tonic.

From a therapeutic point of view the author considers the drug contra-indicated in all nervous affections, among which he includes exophthalmic goitre, in which disease the pneumogastric nerve is paretic. He gives with success the iodide of potassium in fatty heart, in coronary sclerosis, in over-acting heart, in angina pectoris, and in the irregular heart of the aged.—*La France Médicale*, Oct. 10, 1889.

Peabody (G. L.) on Chloralamide.[1] —In Peabody's experience, a headache the next morning was of frequent occurrence following a dose of this drug; but he had never known the stomach or digestion to be disturbed by it. It has the advantage of being much less irritating to the mucous membrane than chloral. It can be well given in powder—not being deliquescent,—or dissolved in wine or spirits. Its solution becomes easier if the vehicle is warmed. Its taste is less unpleasant than that of chloral hydrate.

Dr. Peabody has found it useful in all varieties of insomnia which are not accompanied by pain. In phthisis it had given good results in his hands; also in alcoholism, in fracture of the base of the skull, in intermittent fever, in typhoid fever, in phthisis complicated by alcoholism, in pneumonia, and in cerebral hemorrhage with very great restlessness. In two cases of neuralgia with insomnia it gave great relief. One of them was a pregnant woman with severe neuralgic pains in the thigh; the other was a case of multiple neuritis of alcoholic origin. It had never produced any alarming symptoms of any kind, and the only unpleasant one caused by it in his hands was headache. This headache usually passed off early in the forenoon. There is no such drowsiness the next day as there is after sulphonal, but it has not seemed quite as certain in its effects as the latter drug.—*Med. Record*, Nov. 16, 1889.

A Heroic Dose of Chloral.—Dr. A. C. Free, of Harrisburg, Pa., narrates an interesting case of which the following is an abstract:

A woman, of twenty-six, was suddenly seized with convulsions when six and one half months advanced in pregnancy. Two weeks before this she had received a blow on the abdomen.

On examination it was found that the child was dead; there were no labor pains, and the mouth of the uterus was high in the pelvis and closed. The urine was very albuminous. Convulsions and deep stupor alternated. After two hours' hard work the uterine canal was dilated, and then in a short time emptied of its contents and induced to contract.

The convulsions continued, and it was finally decided to try the effect of ninety grains of chloral hydrate by the rectum. Such a dose was regarded as heroic and dangerous, but the patient was *in extremis*. One hour afterwards the convulsions had not been repeated, but the pulse was becoming thready and almost imperceptible, and respiration was performed in gasps at long intervals. An ominous rattle in the throat made the outlook gloomy. Believing, from the woman's looks, that it was possible to pour a stimulant down her throat, two ounces of whiskey and twenty grains of quinine were used in the attempt. It came near finishing the career of the woman in short order; but, in spite of a fit of strangling, it was retained. In twen-

[1] See MEDICAL ANALECTIC, 1889, pp. 505, 506.

ty minutes the pulse had gained perceptibly in strength, but the breathing was the same. At 11 P.M. two ounces more of raw whiskey were poured into her, but an interval of half an hour seemed to make no difference in her condition.

Early the next morning the patient called for a drink of water. A few minutes later she was found in a semi-comatose state, asking for water every minute or two. Her mouth was as dry as any thing could well be; the mucous lining of the buccal and pharyngeal cavities was glazed and shining, and on the tongue was a dark-brown coating, which was cracked and fissured. Little jagged points, hard and sharp, stuck up all over its surface.

At 8 o'clock, A.M., the woman opened her eyes and commenced to talk rationally. The patient made a good recovery, and has since been delivered of two children without trouble of any kind.—*Times and Register*, Nov. 16, 1889.

Robin on the Action of Thallin.—The author has studied this drug experimentally, and finds that its antipyretic properties are due to its toxic action upon the nervous system and red blood globules. It retards the elimination of uric acid, and hence is unfit for use in all affections having a uræmic tendency, particularly in nephritis and rheumatic affections. Its prolonged use leads to a fatal anæmia or a nervous upsetting more or less marked. As a result of his studies he concludes that the drug is unfit for therapeutic use. Loye arrived at practically the same conclusions in 1885 when he demonstrated that thallin destroyed hemoglobin, was a poison to red blood corpuscles, and diminished the respiratory capacity of the blood.—*L'Union Méd.*, Oct. 17 and 24, 1889.

Cheron (J.) on the Treatment of Dysmenorrhœa by Subcutaneous Injections of Phenic Acid.—The author had employed hypodermic injections of pure water but, as they had caused some pain, phenic acid was added, rendering the injection painless and notably augmenting the sedation produced by the drug. This practice renders it less often necessary to resort to morphine and obviates the necessity of giving drugs by the mouth when the stomach is often irritable.

While useful in all painful conditions of the pelvic viscera, it is chiefly beneficial in dysmenorrhœa. A two per cent. solution of phenic acid in sterilized and distilled water is recommended, and one to four drachms are injected two or three times a day in the abdominal wall or sacro-lumbar region according to the seat of the pain. The treatment seems to be entirely harmless, as much as two ounces of the solution having been injected at a single seance.—*Rev. Méd. Chir. des Maladies des Femmes*, Oct. 25, 1889.

Chloroform and Locomotor Ataxy.—Dr. Thiem, having had to give a patient with slight signs of locomotor ataxy chloroform for the purpose of examining an abdominal tumor, was surprised to notice that as she was being helped from the room, while still somewhat under the influence of the chloroform, she walked with a typical ataxic gait, though this symptom was not ordinarily present. On watching other patients who were not suffering from this affection trying to walk while still partially under the influence of chloroform, Dr. Thiem convinced himself that the peculiar gait only occurred in the subjects of ataxia in whom the semi-narcotic state brings out the want of coördination in the movements of the legs. The explanation would appear to be that inasmuch as the peculiar gait is not due to any paralysis of the muscles, but only to the want of coördinating power, which is set in action by the control exerted by the muscular sense and the sense of sight, when, as in the case of a half-chloroformed subject of locomotor ataxy, both the central coördinating apparatus and the peripheral regulating machinery are in a more or less inactive condition, there is a double reason for the existence of the well-known jerking and sliding movements of these patients. It would appear, then, that in doubtful cases of locomotor ataxy some assistance towards a correct diagnosis might sometimes be obtained by partially anæsthetizing the patient and then observing his gait as he walks across the room.—*Lancet*, Nov. 16, 1889.

Audic on the Action of Camphor upon Iodoform.—The author finds that cold alcohol dissolves only 1¼ % of iodoform, while, if the alcohol is previously saturated with camphor, it will dissolve 10 %. Camphorated ether acts in the same way.

Iodoform being soluble in volatile oils, it is not strange that camphor, which is only a concrete volatile oil, has the same property. The much stronger solutions thus made

will certainly be found serviceable in surgical practice.—*Jour. des Sci. Méd. de Lille*, Oct. 18, 1889.

Hebra on the Hypodermatic Use of Mercury in Syphilis.—One disadvantage against its use is the pain, but this is reduced to a minimum by many of the solutions. The pain usually lasts twenty-four hours after the injection till the fourth day, when the pain disappears. Another alleged disadvantage is the local abscess, but this has not occurred to me in a single case out of 16,000. But this is not the case with all. Breslau has four per cent. in abscess, Bender gives 29 per cent. while other clinics are different. Stomatitis mercurialis is another disadvantage—Breslau's clinic 6 per cent., Bonn 29 per cent., but these are numbers greater than in Vienna. The affecting of the bowel is rare, but Kruno relates one case where 0.1 grain calomel produced dysentery and peritonitis with subsequent death.—*Medical Press*, Oct. 30, 1889.

Somnal.—A new hypnotic, which has been named somnal, is described in a Berlin pharmaceutical journal by Herr Radlauer, who states that, chemically speaking, it is ethylated chloral-urethan, its formula being $C_7H_{12}Cl_3O_3N$. It has a melting point of 42° C., and boils *in vacuo* at 145° C. It is not acted upon by nitrate of silver nor by acids, and can be prescribed in half-drachm doses, dissolved in water with a little syrup of some kind. As a rule, a dose such as this acts in about half an hour, and produces six or eight hours' sleep. No unpleasant after-effects have been observed. There appears to be no interference with the digestive, circulatory, or respiratory organs, so that, according to the writer, the new drug has all the advantages of chloral without any of its disadvantages.—*Lancet*, Nov. 16, 1889.

Erwin (J. C.) on Resorcin as a Substitute for Quinine.—In the simple forms of intermittent fevers, I have found resorcin a most valuable agent. I have used it in many cases of chronic chills, where quinine had been used until it had apparently lost its virtues, only stopping the paroxysms for a few days at a time, and have been pleased with its results. In fact I do not remember at present a single instance when it has failed to give entire relief. In two cases recently I had, in the acute stage, been giving quinine until the paroxysms were controlled, and followed this with a tonic composed of iron, quinine, and strychnine for several weeks. The improvement was not as marked as I had hoped for, and at the end of three weeks the chills returned and were as severe as at first. I stopped the iron, quinine, and strychnine, and prescribed resorcin ʒ ij, aqua ℥ iij; Sig.: teaspoonful three times a day. My patients improved rapidly, had no more chills, or any manifestations of malaria. An intelligent and competent brother practitioner applied to me for a prescription in a very stubborn case of intermittent fever. In giving me the history of the case, he told me the usual remedies had been exhausted, and had failed to give any relief. I suggested resorcin as in the above cases, and he consented with much doubt and reluctancy to give it a trial; suffice it to say that prompt relief followed.—*Texas Cour.-Record of Med.*, Nov., 1889.

ORTHOPÆDIC SURGERY.

Jones (R.) on the Treatment of Club-Hand.—I have seen more cases where the flexor muscles are shortened, and the palmar surface of the hand is flexed on the forearm, and I will first allude to the treatment of such. The sooner treatment is commenced the easier becomes the surgeon's task, and I have treated infants only seven days old. The hands should be held by the surgeon, and gently stretched every morning for some days, the severity of the stretching to be gradually intensified until extension can be made by the hand without any great force. I next place in each of the infant's hands a small wooden bar, allowing the fingers to curl over it—grasp it in fact. Bandage is then used to hold the bar in position, and should be re-adjusted every one or two days according to the severity of the grip. In a fortnight or three weeks, providing good progress is being made, I turn my attention to the wrist, and having removed the bars from the hand, place the forearm in a splint, so constructed as to gradually straighten the hand and wrist. This is best attained by employing a zinc or sheet-iron splint which the surgeon can from time to time bend. Flexor massage may now be employed, either by means of thumb pressure along the separate muscles, by friction, or by flagellation. The hands should next be placed in full extension, and the

splints modified, so as to admit of maintaining them in the extended position. This is practically the last phase of treatment, and the hands should be maintained in this position until all tendency to contraction has ceased. This may take a great many weeks, but in my experience always occurs. By this method the lengthened extensor muscles become shortened and the flexors stretched, and the muscular equilibrium becomes more directly restored than any other treatment will admit of.—*Provincial Med. Jour.*, Aug. 1, 1889.

Fowler (G. R.) on Partial Resection of the Head of the First Metatarsal Bone for Hallux Valgus.—The occurrence of this deformity is attributed to the wearing of faulty-shaped shoes.

The operation was as follows:

An incision was made from a point upon the dorsum of the foot, somewhat below the level of the head of the first metatarsal bone, and just outside of that portion of the tendon of the extensor brevis digitorum which goes to the great toe; this was continued to the bottom of the web between the first and great toes. A similar incision was made on the plantar surface of the foot, slightly to the outer side of the line of the tendon of the flexor longus pollicis. The intervening parts were divided through the whole thickness of the sole of the foot, so as to join these two incisions. The great toe was then strongly adducted, and the external lateral ligament divided, opening the joint. After freeing the soft parts from the neck of the first metatarsal bone with the handle of a scalpel, the phalanx was completely displaced. The great toe was adducted still further, until its inner border lay along the inner border of the foot, its point looking directly backward; the head and neck of the first metatarsal bone, together with a large exostosis constituting the "bunion," was thus freely exposed. The latter, together with the inner half of the articular surface of the former, were sawn off by an oblique cut. The toe was then replaced in its normal position, and drainage provided for by a tube in the bottom of the gap. The soft parts were sutured; dressings of sublimate gauze and paper wool, and a splint, were applied to retain the toe in a straight position. The other foot was operated upon in the same manner. Union of the wound in the left foot was somewhat delayed by the occurrence of slight suppuration. In three weeks, however, the patient could walk comfortably, but was kept under observation until the end of the sixth week, when she was discharged from the hospital cured.

The after-treatment consisted in a stocking and a shoe with a separate stall for the great toe.—*Med. Record*, Sept. 7, 1889.

Ridlon (J.) Notes on Two Cases of Hip-Disease in which Traction Caused Severe Pain.—Two cases are narrated in detail. The first had no pain before treatment was commenced; pain came on when the traction splint was applied, and disappeared when traction was relaxed and the splint used simply as an ischiatic crutch. The second had pain when traction was made by the hip-splint and abscess appeared. Traction was relaxed and the abscess aspirated. It did not refill until traction was again applied, and disappeared without a second aspiration when traction was again dispensed with. Thomas' splint was then applied and an early cure without further pain or abscess resulted.

The writer believes that all cases of hip-disease should receive, as nearly as it is possible to attain it, absolute immobilization of the joint so long as there is any inflammation existing at the joint; that in all cases the superincumbent weight should be removed until convalescence is well established; that in some cases traction added to fixation sooner relieves the pain due to involuntary muscular spasm than fixation alone; that in very many cases traction is neither demanded by the symptoms presenting nor in any way advantageous; and, finally, that in some few cases it is positively harmful. As to all forms of the traction hip-splint with which I am familiar, I desire to say, that in no one of them is constant, uninterrupted traction attained during locomotion; and that I believe that the push-and-pull action of these splints during locomotion is the opposite of proper treatment.—*Medical Chips*, Aug. 1889.

Blanchard (W.) on the Treatment of Hip-Disease.—The author uses a splint made as follows: An inflexible strip of iron, known as "binding," is bent to the form of the body and made to extend from the lower angle of the scapula to the heel on the affected side. This secures nearly complete immobility. Direct extension and counter-extension are made from bands riveted to the main upright at ankle and waist. A spring is made to reach from

the outside of the knee to the crest of the ilium, to which is attached a soft, padded band passing around inside the thigh, by means of which all the lateral extension is exerted, which the patient will tolerate. Both extensions being equal, the mean extension will be in an axis with the neck of the femur. Put a high shoe under the foot of the unaffected side, provide a pair of crutches, and insist on plenty of out-door exercise, the more the better, for the diseased joint is now fully protected from accident.—*Medical Standard*, Nov., 1889.

Phelps (A. M.) on the Management of Hip-Joint Disease from an Anatomical Basis.—The author believed in regard to the pathology of hip-disease, that it was a local tuberculous affection, due to accidental inoculation and not to a constitutional or strumous condition. Following Volkmann, Albert, and König, he believed that the inflammation, at first simple, became tubercular by inoculation, and then purulent. The irritation of the peripheral extremities of the nerves in or about the joint produced muscular spasm, which in turn distorted the joint by trauma, aided by the bacilli of tuberculosis. In regard to treatment, he relied on mechanical treatment, believing that if we immobilized a joint and removed the intra-articular pressure, nature would take care of the tuberculous material. His experiments on dogs had convinced him that immobilization of healthy joints did not produce ankylosis. Encouraging motion in an inflamed joint was a violation of the surgical law that an inflamed part required rest. He believed that the muscular spasm, which was a most dangerous element of destruction, should be overcome by extension, and that, while extension was necessary to secure immobilization, it was not sufficient by itself. He therefore resorted to a combination of extension and fixation, the exetnsion always to be in a line corresponding to the axis of the neck of the femur.

Treatment, as a rule, should be begun in bed, extension being made in two directions—*i. e.*, toward the footboard and laterally, the body and the sound leg being fixed to a long splint extending to the axilla. If the deformity did not yield to extension properly applied, the tissues at fault should be divided subcutaneously or by open incision. Abscesses were to be incised through their entire length, and thoroughly scooped out and washed, strict antiseptic precautions being observed. Distension of the capsule should be relieved by aspiration or incision; then traction would not produce pain.

He exhibited a patient in a portable bed, which was an ingenious substitute for the wire cuirass, made with a board cut in an outline of the body and plaster-of-Paris. The child was laid on the board, and then the whole was enveloped with plaster-of-Paris bandages from the foot to the axilla. The plaster was then cut away in front, the interior comfortably padded, and the patient held in place by lacings or bandages. Extension and fixation in bed were to be continued until the active symptoms and the deformity had entirely disappeared, and the spasm of the muscles was no longer present. Adults were then given crutches, and a portable splint which had a perineal crutch, extension by adhesive plaster, an abduction bar, and an upper (thoracic) ring to prevent flexion and extension at the hip. Children, after treatment in bed, were to have the portable bed, and then the portable splint, with or without the high shoe and crutches.—*N. Y. Med. Four.*, April 31, 1889.

JOHN RIDLON, M.D.

DISEASES OF THE EYE AND EAR.

Derby (H.) on Some Causes of Preventable Blindness.—According to the figures given by Dr. Lucien Howe,[1] blindness in the United States increases at a rate out of proportion to that of the growth of the population. Between 1870 and 1880 the latter had increased 30.09 per cent., and the number of blind 140.78 per cent. The community is supposed to have been, in 1880, at a charge of between sixteen and seventeen millions of dollars for the support of these individuals.

A certain proportion of this loss of sight is, of course, preventable. Being desirous of estimating the relative number of such cases in our own community, I recently applied for permission to examine the inmates of the Perkins Institution for the Blind in South Boston. I was thus enabled to take notes of 183 cases.

Following the classification of Magnus, I

[1] Transactions Am. Ophth. Society, vol. iv., p. 532.

have divided these cases into four classes, and subdivided them as follows:

I.	CONGENITAL BLINDNESS.		
	Mikrophthalmus	4	
	Megalophthalmus	1	
	Cataract	20	
	Choroiditis	1	
	Atrophy of optic nerves	9	
	Anomalies of cornea	3	38
II.	BLINDNESS IN CONSEQUENCE OF IDIOPATHIC DISEASES OF EYE.		
	Blennorrhœa neonatorum	34	
	Trachoma	4	
	Blennorrhœa	5	
	Disease of cornea	1	
	Irido-choroiditis and cyclitis	5	
	Choroiditis	1	
	Separation of retina	1	
	Idiopathic optic-nerve atrophy	4	55
III.	BLINDNESS OF TRAUMATIC ORIGIN.		
	Direct injury of the eyes	9	
	Unsuccessful operations	3	
	Injuries of the head	16	
	Traumatic sympathetic ophthalmia,	12	40
IV.	BLINDNESS ATTRIBUTABLE TO GENERAL DISEASE.		
	Syphilis	1	
	Brain (atrophy of optic nerves)	27	
	Typhoid	1	
	Measles	5	
	Scarlet-fever	16	55
			183

It is with the figures in the second class that we are more immediately concerned, and especially with those of blindness dependent on the ophthalmia of new-born children. There were 34 cases out of 183, being a percentage of about 18.6. This is, however, a smaller proportion than has been obtained by other observers.

This examination reveals the fact that at least one in every five of the inmates of the institution need not necessarily have ever come there. For it is an established fact that the ophthalmia of new-born children can, with few exceptions, be successfully prevented when there is reason to apprehend its occurrence. It is also not an exaggeration to claim that hardly a disease of the eye yields with more certainty to appropriate treatment.

Experiments carried on by different observers, controlling ample material, have demonstrated, beyond a doubt, that the purulent infection of the eyes of new-born children can be reduced to a minimum by the use of a disinfectant, and that the most efficacious disinfectant is the nitrate of silver. Credé, the original proposer of the use of nitrate of silver, had, before the introduction of prophylaxis, 314 cases among 2,897 children, 10.8 per cent. After beginning to use the 2-per-cent. solution of nitrate of silver he had but from one to two cases in 1,160 children, being 0.1 to 0.2 per cent.

The 2-per-cent. solution of nitrate of silver gives the surest results, is devoid of danger, causes but trifling irritation, and deserves general use. It is to be applied to each eye as soon as the child has been washed, one or two drops being sufficient. It is not necessary to evert the lids, it having been found that the cornea is not injured if the application be made directly to the eyeball.

Infection after birth may occur through contact with the lochial secretion, or any other want of cleanliness.

Scrupulous cleanliness, the frequent removal of the discharge, and the use of mild astringents, may be by no means sufficient. In the present state of our knowledge it is not presumptuous to assert that a case of this disease terminating in a manner fatal to sight and treated without topical applications of nitrate of silver would be regarded as having been culpably neglected. This is the remedy that acts with the most certainty as a specific against the gonococcus. It is not only antiseptic in its action, but works both superficially and deeply. As has been justly observed, "it causes a sloughing of the upper layer of epithelial cells; if then the micro-organisms have already penetrated there they are followed up and destroyed by the silver solution. Hence the action of the silver solution is so much more certain than that of the carbolic acid mixture."[1] It is to the neglect of the timely use of nitrate of silver, and the failure to regularly inspect the cornea and provide in time against its destructive ulceration, that the blindness occurring as a result of this disease is generally due.

There is but one other cause of preventable blindness on which I wish briefly to dwell: traumatic sympathetic ophthalmia, of which I found 12 cases at the Blind Asylum, something over 6 per cent. of all affections investigated. With young children the occasion for the occurrence of this disease is most frequently the wounding of the other eye by forks, scissors and knives carelessly left in their way. As it can be guarded against by the timely removal of the injured eye, it is certainly

[1] Fuchs: Die Ursachen und die Verhuetung der Blindheit, pp. 132, 133.

desirable that the indications for the performance of this operation should be familiar to the profession. They may be condensed as follows :

The injured eye should be removed when :

(*a*) It contains a foreign body that cannot be extracted without destroying the eye.

(*b*) The nature of the injury is such that sight is unlikely to return, and there is danger of sympathetic disturbance.

(*c*) There is tenderness on pressure, vision having been destroyed.

There are other rules laid down, but these are the most plain and practical. Had they been understood and followed in the twelve cases seen by me, it is safe to infer that no one of these individuals would have become an inmate of the asylum.

To sum up the results of my investigation, I found 34 cases of ophthalmia neonatorum, 4 of trachoma, and 12 of the results of sympathetic ophthalmia ; together, 50 instances of preventable blindness ; in all, 27 per cent. of the inmates of the South Boston Asylum who need never have gone there had they received suitable care or enlightened treatment at the proper time. To diminish such a percentage in the future the more careful medical education of the present day will not alone suffice. Those who propose to follow the profession of nursing must also be properly instructed, and some degree of knowledge on these subjects be diffused in the community.—*Boston Med. and Surg. Jour.*, Oct. 24, 1889.

Atkin on Complete Mydriasis from a Blow on the Eyeball.—After nearly four months' treatment no contraction had been effected. It was assumed that the same irritation which had paralyzed the fibres of the third nerve had stimulated those of the sympathetic. Recent experiments were quoted to show that it was probable that all branches proceeding from the Gasserian ganglion contained motor fibres, and that it was probable that the dilator of the pupil was supplied also by the fifth nerve. As myotics, cauterization, and electricity had been tried ; irritation of branches of the fifth nerve and ocular gymnastics were suggested as most likely to succeed ; but reservation was made that if Dr. Woake's theory of the reflex relationship of the afferent and efferent elements of the sympathetic system were correct, then stimulating the branches of the fifth nerve might act reflexly on the dilator, as well as on the contractor of the pupil, and so nullify any result.—*Br. Med. Jour.*, Nov. 2, 1889.

SURGERY.

Terrier on Cholecystenterotomy.—A woman of fifty-four was seized, after an attack of hepatic colic, with general icterus, colorless stools, cramps, extreme weakness, and absolute anorexia. This condition continuing, the author operated. He found the common bile duct obliterated, and established a communication between the gall bladder and first portion of the duodenum. This operation, performed for the first time in France, resulted in a complete success.—*La Tribune Méd.*, Oct. 31, 1889.

Picqué on Construction of a Vagina by an Autoplastic Process.—The patient was a girl of eighteen, with a normal vulva, no vagina, an infantile uterus, and without retention of the menses. The author created a vagina after the method of Amussat. He sought to remedy cicatricial contraction by slipping the mucous membrane of the vestibule upon the roof and the skin of the perineum upon the floor of the vagina. The results of the operation remained five months after operation—*L'Union Méd.*, Oct. 29, 1889.

Treatment of Ingrowing Toe-Nail.—There is no lack of suggestions for the treatment of this painful infirmity, but as none of them are absolutely reliable, one is disposed to welcome new-comers of avowable origin. Dr. Clemens, of Frankfort, recommends the use of tin-foil. After carefully washing the toe with soap and water, and then wiping the affected nail perfectly dry, he spreads a layer of tin-foil in such wise as to envelop the nail in its entirety. At the same time narrow slips of the foil are insinuated between the edge and the ulcerated flesh. The dressing is fixed *in situ* by means of a little yellow wax, and need not be changed oftener than once in three days. The foot should not be washed while the treatment is in progress, it being kept clean by rubbing with dry bran. The cure is rapid, even if the patient continues to walk about in ill-fitting boots, as most of Dr. Clemens' patients are reported to have done.—*Med. Press*, Nov. 6, 1889.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLE.

Shaw (T. C.) on the Surgical Treatment of General Paralysis.—The hopelessness of remedies to stay the progress of general paralysis of the insane has led me to consider the advisability of trying surgical interference at an early stage of the disease, and I beg to submit the following case where trephining was performed with the result that the prominent symptoms disappeared. Whether general paralysis is a disease *sui generis* or not, it is certain that the pathological appearances point to irritative (probably inflammatory) processes in the upper layers of the convolutions in the earlier stages, and to pressure signs from the presence of fluid in the later.

To modify these conditions is the object of the operation, but beyond suggesting that by producing an alteration in the existing state of the morbid process at work a new and reparative nutritive process may be set up, I do not at present offer an explanation. This, however, must be borne in mind, that early headache of a tensive character is a very frequent symptom, and that trephining seems to be a more certain way of relieving the pressure than depletion by purgatives or medicines given with the view of lowering vascular tension. How nerve-stretching acts in ataxy is not known, though of its efficacy there is no doubt. Why should not the same process have favorable results when applied to the brain? The only way of stretching the brain is by giving it more space in which to expand, by allowing it to relieve itself from the increased arterial tension which the sphygmograph has shown to be one of the early conditions in general paralysis. It is easy to see how surely trephining must relieve the later symptoms due directly to fluid pressure, such as the paralyses, attacks of stupidity, loss of power of swallowing, talking, etc. To propose trephining in the early stage of a disease seems a formidable remedy, but the operation is nowadays attended with little risk, whilst the steady progress towards death if the disease is left to itself makes it imperative to consider the feasibility of any remedial measure, however severe.

Occasionally we read of cases of general paralysis recovering in an unexpected manner; but without denying the correctness of the reported instances, it must be said that they are so few in number, and so obscure in the description of the manner in which the cure was effected, that we must put them out of the category of results most likely to happen. Acting, then, on the principle that the relief of tension and the endeavor to set up a changed nutritive process was to be the guiding one for treatment, and that to be of any value it must be done in an early stage, I communicated with Dr. Ferrier, and asked him to see with me the case of a man upon whom I proposed to operate. We agreed that the patient was rapidly approaching a condition of dementia of the paralytic form, and that the only hope of giving him relief was in the manner I am now indicating. The great difficulty that one has to contend

with is in getting the consent of the friends for the operation to be performed, for the signs which have so fatal an import to those conversant with the disease are not especially striking to the uninitiated.

The main features of the case are as follows: W. H., admitted November 14, 1888, a packer, in an excited grandiose mental state, affection of speech, exaggerated reflexes, gait very unsteady, and retention of urine. On the certificate of admission his delusions were described as very "large" in extent, and there was no doubt that when admitted he was in an elevated and happy frame of mind, altogether incompatible with a realization of his true condition. It was probable that the man was suffering from a bulbar lesion, and that the mischief, which had probably begun there, was extending to the superficial parts of the brain. From time to time W. H. had convulsive attacks and short periods of loss of sensation, chiefly in the left extremities, and his powers of deglutition and talking became more and more impaired, whilst his mental condition was fast approaching a well established dementia. On July 28th the patient was trephined on the right side of the skull over the central sulcus, and about two inches outside of the longitudinal fissure.

The operation, performed by Mr. Harrison Cripps, assisted by Mr. Bruce Clarke, consisted of making two holes with a trephine, cutting away the intermediate bone so as to make an opening about 1½ inch long by ¾ inch wide, cutting away the dura mater, and letting out a considerable quantity of subarachnoid fluid.

Strict antiseptic precautions were taken, and the after-course of the operation was very satisfactory, for at no time did the temperature exceed 99.5 °, and by the tenth day healing was complete, and the patient was able to sit out of bed. With the exception of a little tingling in the fingers of the left hand on August 9th and 15th, there have been no cerebral symptoms since the operation. The present state of the patient is a great improvement upon what it was; in fact, he is no longer insane, and I propose to discharge him. We did not expect him to show any marked improvement in the bulbar symptoms, although I think that even here his condition is better, and he certainly swallows and speaks more easily and distinctly; but in his mental tone the difference is most marked, for he is no longer optimistic in his ideas, nor has he had any of the convulsive epileptoid attacks, to which, before operation, he was very subject. He reads the paper daily, is free from headache, eats and sleeps well, and is able to hold his urine. I pointed out the case to Dr. Clifford Allbutt on the occasion of his recent visit here, and he agreed that the man could no longer be considered insane.

I consider, then, that the operation has been justified by success, inasmuch as the mental signs of exaltation have disappeared, together with the convulsive attacks; and though the prominent bulbar symptoms remain, they have to some extent been benefited, beyond which we expected nothing. My object in reporting this case is that I believe it to be the first that has been done with the distinct object of introducing surgical measures into the early treatment of general paralysis; at any rate, I am not aware of any other reported case, nor have I before heard this mode of treatment suggested.

Little can, of course, be postulated from one operation, but the results of this case have been so satisfactory that I feel encouraged to go on, and I shall hope to be able to report additional successes from time to time.—*Br. Med. Jour.*, Nov. 16, 1889.

OCCASIONAL REPORT UPON SURGERY.

BY CHARLES A. POWERS, M.D.

Bull (W. T.) on Suturing the Tendon of the Quadriceps Femoris.—A boy aged seventeen was admitted to the hospital in April last with a wound one and three-quarters of an inch in length above the patella, made by a circular saw. The tendon of the quadriceps had been cut directly across immediately above the patella. An incision was made three inches in length from the patella upward, and the tendon was sutured with catgut, the joint drained, and knee enveloped in an antiseptic dressing. There was at no time any suppuration, and the patient went about the wards with a plaster-of-Paris splint at the end of ten days. At the present time the power of extension had become normal, and the joint movement free.

In such a case as this, he said, in which there was an open wound, no one would

hesitate to suture the divided tendon, but in other cases in which the rupture was subcutaneous the question of whether it was best to cut down and suture, or to leave the ends to unite without such operation, had not yet been settled.

In view of the good results in other cases which had been under his care and which had been subjected to operation, he would be disposed to operate.—*Med. Record*, Nov. 23, 1889.

Gross (F. H.) on Ruptured Quadriceps Tendon.—The injury was received March 2d, and the case at once came to the hospital. There did not seem to be any opportunity for applying sutures. There is a fair degree of usefulness, mainly through the accessory tendons of the vasti muscles. It occurred to him that it might be advisable to transplant the lower attachment of these tendons to the region of the ligamentum patella.—*Med. News*, Aug. 17, 1889.

[The result in this case would seem to strengthen the position taken by Dr. Bull regarding the advisability of immediate suture.—C. A. P.]

Wiener (R. G.) on Suture of Ruptured Patellar Tendon.—The man had been operated on by the late Dr. H. B. Sands five years ago for ruptured patellar tendon, the result being perfect. In December last the man fell downstairs and ruptured the tendon again. He was transferred to Dr. Wiener's service at Charity Hospital in June last. He found the patella about four inches above the joint-line; power of extension entirely gone. He made an incision nine inches long over the joint, but found no remnants looking like patellar tendon. He then tried to use tissue on the lower part, shaping it somewhat like the tendon, but was unable to draw the patella down, and consequently was obliged to make complete section of the quadriceps tendon. Then, in order to bring the bone to its place, he had to drill and wire the patella and tibia, and then suture together the remains of the tendon on the two bones. Primary union took place, and the patient left the hospital at the end of three months, able to walk on the leg.—*Med. Record*, Nov. 23, 1889.

Bradford (E. H.) on Ligature of the Internal Jugular Vein.—The author was dividing the sterno-mastoid muscle, for wry neck, by open incision. At the bottom of the wound a small tense fibre was felt. It was thought advisable to divide this to make permanent connection more certain.

The fibre was therefore raised between two pairs of forceps, and an incision carefully made between them. A slight amount of venous blood came from the wound, but it was readily controlled by pressure-forceps. An attempt was made to ligate this point, but the ligature came away on irrigating the wound. This was followed by a recurrence of bleeding, which was not profuse, but persistent. Several attempts made at ligature were unsuccessful. No vein could be seen, and it was thought that the bleeding came from an anomalous vein lying in the muscular tissue close to the deep fascia. An attempt was made, by passing a needle, to secure the small mass of muscular tissue which appeared to overlie the bleeding-point. The hemorrhage was easily controlled by pressure-forceps, but became quite profuse when the forceps were removed. It was then determined to carefully expose the bleeding-point by incision, and it was found necessary to incise the deep cervical fascia. When this was done, the blood was seen to come from a small incision in the internal jugular vein about an inch above the clavicle. The vein was distended about the size of a little finger. A bent probe was passed under the whole vein, with a silk ligature threaded through the eye end This was carefully pulled through, and the vein was tied above and below the bleeding-point. The hemorrhage then ceased, and the wound was sewed up. The patient made a rapid recovery.

The case may serve as illustrating two points: (1) That, incising the deeper portions of the attachment of the sterno-cleido-mastoid, it should be borne in mind how near they lie to the internal jugular vein, being separated from it (if the neck is straightened) only by the layer of deep fascia. (2) That, in dividing any remaining contracted fibres, the deep tissues should not be raised by forceps, as a portion of the vein may readily be pinched and raised also.—*Boston Med. and Surg. Jour.*, Aug. 29, 1889.

Wight (J. S.) on Forward Dislocation of the Ulna.—The patient, a laborer fifty years of age, fell from an office stool to the floor, striking on the left elbow. The internal condyle and the trochlea were easily felt from behind under the skin and

fascia, and their outline could even be seen. The olecranon and the base of the ulna were absent from their normal place, the head of the radius was in its normal relation with the external condyle; the radius was not dislocated. The olecranon and the base of the ulna could be distinctly made out in front of the lower end of the humerus.

The coronoid process of the ulna and the sigmoid notch of the olecranon could be traced under the soft parts in front of the elbow. And when the forearm was moved, the coronoid process and the olecranon also moved in their abnormal position, as they could be distinctly felt. The forearm could be adducted to a very considerable extent. Flexion of the forearm was mostly absent. The upper and inner side of the forearm was abnormally prominent. Reduction was accomplished by abduction, which carried the olecranon inward and downward; supination, which lifted the upper end of the ulna out of its abnormal position; pronation then carried the ulna backward; and pressure, accompanied by flexion and extension, moved the ulna downward and inward to its normal position.—*Brooklyn Med. Jour.*, Sept., 1889.

Mynter (H.) on Traumatic Loss of the Biceps Muscle.—The patient was caught by a rope and drawn into a cog-wheel, which, besides producing a great many lacerated and torn wounds, completely tore out the biceps muscle of his right arm, severing it in the centre and leaving the upper and lower half attached only by their tendons. The tendons were cut over, the dead muscle removed, and the enormous wound healed by skin-grafting. The biceps is the principal flexor and supinator of the forearm, and we should, therefore, expect a considerable or almost complete loss of these movements. He can, nevertheless, flex and supinate his forearm by aid of musculi brachialis internus, pronator teres, and supinator longus as flexors, and supinator brevis as supinator. Remarkably enough, he scarcely seems to notice his loss.—*Buffalo Med. and Surg. Jour.*, Sept., 1889.

Beach (H. H. A.) on Tuberculosis of Sheath of Extensor Tendons of Foot.—Patient a woman of forty years. Family history good. One year ago a small swelling appeared on the dorsum of the right foot without any injury or other cause to explain it. It has increased without pain, until now it measures the size of a lemon; the surface red, moderately tender, without thrill or pulsation, and does not impede walking. A slight enlargement of the inguinal glands of both groins may be felt. An exploratory incision disclosed a mass of cheesy nodules in a matrix of translucent gelatiniform material with some small pockets containing a thin yellow fluid, all connected with the sheaths of the tendons of the extensor longus digitorum muscle. Microscopical examination showed the growth to be due to an infiltration of tubercle. The mass was excised and the remaining surface curetted. The cavity left was packed with iodoform gauze, and healed in due course of time.—*Boston Med. and Surg. Jour.*, June 6, 1889.

Wyeth (J. A.) on Cystotomy.—The author, after detailing eight cases of supra-pubic cystotomy occurring in his own practice, arrives at the following conclusions: 1. For the removal of tumors there can be no hesitation in preferring the high operation to perineal cystotomy. By no other method can a safe and thorough removal of a neoplasm be effected. 2. In vesical calculus, without regard to size, the supra-pubic operation is preferable in hypertrophy of the prostate, where this organ is elongated and thickened, and has thus made the cavity of the bladder more difficult of access. 3. In large calculus—two inches in diameter and over—the high operation should be chosen. 4. For stone in the female bladder it should be invariably selected, when the calculus is too large or too firm to be crushed and removed per urethram. 5. In male children perineal section for stone may be preferred, since the perineum is not deep, the organ quite easy of access, and the after-treatment less troublesome. 6. In female children supra-pubic cystotomy should be done when the calculus is more than one half inch in diameter. 7. For foreign bodies other than calculi, not safely removable with the lithotrite, the same rules would apply as for stone. 8. As between lithotrity and cystotomy I am of the opinion that when the urethra is normal, the bladder not materially diseased (and therefore not in great need of the rest which drainage after cystotomy secures), the stone soft enough to be crushed, and not over two inches in diameter, lithotrity should be done, *always provided that the*

operator is well versed in the technique of this operation. I do not know of a procedure requiring greater skill, a more practised hand, and clearer head than lithotrity. Given a tyro at both procedures, then by all means the high operation, for here, if the lines are adhered to, the end will be attained. 9. In drainage of the bladder for chronic cystitis in women, when the drainage is to be continued for many weeks and a urinal worn, the vaginal operation is indicated. For temporary drainage the high operation is best, since the wound closes spontaneously after the tube is removed. 10. In males I prefer the high section for drainage, for the reason that a fistula in the perineum offers more difficulty to close than one through the abdominal wall above the pubes. 11. I consider the chief objection to this operation to be the tendency to establishment of a fistula in the track of the wound. It is probable that this tendency will he greatly lessened by an early removal of the tube, say on the third or fourth day.—*Med. Record*, Aug. 17, 1889.

Solonika (N. V.) on Suprapubic Cystotomy.—The author concludes that the choice between the high and median operations must be based on the following general postulates: *a.* In cases of small-sized calculi, measuring under two cm. in diameter, median lithotomy should be performed, which allows an easy removal of the concretions without crushing them or inflicting any traumatic injuries to the bladder and prostate. The after course in such cases is usually very good; the operation does not leave any fistula or incontinence of urine. Very often the latter commences to flow *per vias naturales* even on the second day, while the wound heals rapidly *per primam.* *b.* In cases of larger stones, the high operation is by far the better of the two. Most frequently, it secures an excellent after-course and complete cure. Any untoward results are observed much less frequently than in cases of median section (when the latter is resorted to in cases of the kind). *c.* In all cases where the stone is lying in a diverticulum, or if tightly grasped by the vesical walls, or where the calculi are multiple, or where there is present a vesico-prostatic stone, the high operation must be invariably performed, since it gives in such cases by far more satisfactory results than the median one. *d.* Any more or less marked enlargement of the prostate constitutes a contra-indication in regard to median lithotomy.—Valerius Idelson in the *Annals of Surgery*, Sept., 1889.

Hartley (F.) Operations upon Struma.—Of the various incisions used in partial or complete extirpations of the thyroid gland the author prefers Kocher's. It gives the most perfect and complete survey of the whole field of the operation, and an excellent chance to ligate the veins and arteries without difficulty. So perfect is the field offered by this incision that the operation can be done with quite as much ease as in a dissection upon the cadaver. The veins and muscles are recognized in their respective relations to one another, and are undisturbed by the line of incision or the slight traction given to the margins of the wound by the retractors. Moreover, the exposure of the trachea where the gland is attached and of the inner surface of the inferior horns of the lateral lobes where the thyreoideæ imæ veins are present, and which in struma substernalis must be rendered free for litigation, seems to be perfect. The upper oblique portion of the incision, besides dividing the skin and the platysma muscle, crosses the anterior, oblique, and external jugular veins transversely, or at least obliquely, so that they may be secured by double ligatures before proceeding further with the operation.

The median and oblique incisions seem to be best fitted to those cases in which we are to remove strumous nodules either by enucleation (Socin), or *évidement* (Kocher), but not for partial or complete thyreoidectomies or resections.—*N. Y. Med. Jour.*, Aug. 17, 1889.

On the Treatment of Fractured Patella.—The *Medical News*, August 24, 1889, in an editorial, thus sums up the present methods of treating this important lesion:—The old method of immobilization of the joint upon a posterior splint with retention of coapted fragments by bandages will furnish a large percentage of successful results, and is to be employed in default of special instruments, or of the opportunity to carry out operative methods with the necessary protection; but it requires that the fragments should be left uncovered for frequent examination in order that subsequent separation may be promptly detected and remedied.

Malgaigne's hooks, in any of their

modified forms, accomplish their object with much certainty and freedom from risk, but occasionally troublesome suppuration occurs.

The various subcutaneous methods hold out a fair promise of both efficiency and freedom from risk, with the advantage that the patient needs close supervision for only a few days, or until the punctures in the skin shall have healed. He can then be dismissed with a plaster splint, to be worn for a month, with no anxiety lest the adjustment of the fragments should be disturbed.

The operation of opening the joint and wiring the fragments should be used only under exceptional circumstances.

[We have at present no absolute assurance that operative procedure upon the knee joint will not be followed by suppurative processes. In view of this the question may well be raised whether, considering the excellent results obtained by simple confinement of the fragments in accurate and appropriate position, operative procedure of any kind is justifiable in recent cases of ordinary severity.—C. A. P.]

THERAPEUTICS.

Musser (J. H.) on the Oil of Eucalyptus in some Forms of Malaria.—From recent studies the following conclusions may be presented:

First. Intermittent malarial fever is a self-limited disease, and a large number of cases get well on removal from an infected locality.

Second. The oil of eucalyptus is of no service in cases of intermittent fever in the blood of which the organisms that are the possible cause of the malaria are found.

Third. The so-called habit-chills are relieved or checked by the use of the drug.

Fourth. Malarial neuralgias, malarial headaches, and vague intermittent symptoms, even complete but mild paroxysms, independent of the presence of any local organic disease, but due to malarial intoxication, are relieved by eucalyptus. The proof that they are due to malarial intoxication has not thus far been found by an examination of the blood, it is fair to state, but only because of the residence in the malarial locality, and because others in the same locality are affected with the disease.

Fifth. After quinine has controlled the paroxysms of intermittent fever and cleared the blood from organisms, eucalyptus will relieve or cure abortive paroxysms, intermittent neuralgias or headaches, or those marked symptoms of malaise, prostration, loss of appetite, and feverishness that are often seen.

Sixth. A dose of five drops, four times a day, preferably administered in capsule, is sufficient to produce the desired result.—*Med. News*, Dec. 7, 1889.

Philpots (J. R.) on the Treatment of a Common Cold.—Salicylic acid applied locally to the irritated lining membrane of the nose before any inflammatory action is established, that is, when sneezing manifests itself, will generally by a single application abort a common cold. The formula I have suggested is: ℞ Sodii salicylatis, ʒ iv; acid. boracis (pulv.), ʒ i.; cocainæ hydrochlor.; gr. xxii. M. Mix by agitation, not in a mortar. Or even the ordinary Dover's powder well blown into the nose by an insufflator will answer.—*Br. Med. Jour.*, Nov. 16, 1889.

Adams (J. H.) on the Use of Carbolic Acid in Diarrhœa.—In experimentation, in various forms of diarrhœa, with this drug, it was my personal experience, in common with other observers, that the remedy was of more use when the trouble was of long standing, and especially where it had resisted all other treatment. I give the report of three cases:

Case 1.—Woman, aged forty, healthy, plethoric, but with a tendency to diarrhœa on slight cause since childhood. The present diarrhœa had been due to a slight indiscretion in diet; no attempt was made to check the trouble, at first, either by diet, medicine, or rest. As her disorder grew worse, she began to treat herself; paregoric, laudanum, bismuth in large doses, etc., which had served to check her diarrhœa previously, were tried. All served to stop the discharges, somewhat, as long as she remained in bed or on a lounge; but as soon as she attempted to stay on her feet for any length of time the diarrhœa returned with redoubled vigor. She began to feel debilitated, lost her appetite, and suffered from intense griping. As her discharges were scanty, and undoubtedly her bowels were clear from any irritating substances, liquefied crystals of carbolic acid, in three-drop doses, given with bismuth, were ordered; enough of this latter drug

was used to absorb the liquid carbolic acid. This required about twenty grains of bismuth. With rest in bed and a restricted diet, and one of these powders every four hours, a change was gradually brought about. In a short time she was greatly relieved from the tormina and the discharges became normal in two days' time.

CASE 2.—Woman, aged twenty, at service in the country. She had constant diarrhœa for three months before she was seen; this she attributed to the drinking water. She had grown pale, weak, and discouraged. She tried various household remedies without avail; she was able to recognize in the discharges different articles eaten. She was ordered the same prescription as for Case 1; her diet was restricted to boiled milk, and she was told to avoid the suspected water, and to perform as little work as possible. She reported herself as well in five days.

CASE 3.—Colored man, who had brought on slight choleraic symptoms by working in the sun. He had been vomiting, and going to stool excessively for four days before he was seen. He felt a desire to go to the closet on the slightest motion; the movements were small, bloody, and consisted principally of mucus. A prescription was ordered containing carbolic acid; improvement was noticed in a short time. Next day the stools were reduced to six in the twenty-four hours, and in two days more the man was ready for light work.

A good way to administer the drug is to combine it in an emulsion with bismuth and peppermint water. Dr. Davis (*Transactions Ill. Med. Society*, Chicago, 1871) suggests its combination with glycerine and paregoric. The English surgeons always give it in the infusion of gentian or chiretta. — *University Med. Mag.*, Dec., 1889.

Fatal Result of Suspension for Ataxy.—A case of locomotor ataxy, in which suspension was followed by death, was not long ago reported by Dr. C. Borsari, of Modena, in the *Revista Generale Italiana di Clinica Med.*, Oct. 25th. The patient, a man aged forty-five, was in the second stage of the disease, which was complicated by aortic imcompetence. After the first suspension, which lasted fifteen minutes, and was carried out "with every precaution and with the help of a well-constructed apparatus," the patient had momentary anæsthesia in the feet; his face became pale, his eyes glassy, and he complained of giddiness and faintness. These symptoms passed off after a while, and the man was able to walk back to his ward. He was afterwards suspended for short periods on alternate days, though the operation was always followed by increase of staggering in the gait, by convulsive movements of the arms and legs, and by pallor and an expression of distress in the countenance. After three or four sittings, however, there was a notable improvement in motor co-ordination. Later on violent vomiting (an entirely new feature in the case), set in, together with a certain amount of pyrexia, which lasted for forty-eight hours. When the temperature fell to normal he was suspended for the eighth time, the operation lasting forty seconds and being followed by no untoward effect. Soon afterwards, however, the vomiting became worse, and the man complained of intense pain in the epigastrium. This was speedily followed by delirium with convulsions, ending with coma and death three days after the last suspension. The necropsy confirmed the presence of the aortic disease and the characteristic lesions in the spinal cord; in addition to these there were also found signs of acute exudative leptomeningitis, both cerebral and spinal, the latter being in the dorso-cervical region. There was no indication that the affection of the heart had been in any way aggravated by the suspension; and Dr. Borsari leaves it to be settled by further experience whether the acute inflammatory process was set up by the strain to which the membranes of the spinal nerve roots were subjected during suspension. He points out that, although suspension has been performed thousands of times, no similar accident has yet been recorded.—*Br. Med. Jour.*, Nov. 23 1889.

Bashore (H. B.) on Chloroform Water.—Chloroform water has lately proved to be of much value to me in the treatment of false croup, and is in this affection superior, I think, to chloral, in that it is not so dangerous and is eliminated in part by the lungs; of course, its action is purely local and its value, too, probably due to the sedative effect upon the sensitive filaments of the superior laryngeal nerve.

I use a solution consisting of five to ten minims of chloroform to an ounce of water, to which is added a little glycerine to aid

the solubility of the chloroform. A teaspoonful of this is given every half-hour during an attack, and if there is any dyspnœa the following day, a teaspoonful is given every two hours, increased in frequency to every hour during the evening.

This method of treatment—which is especially applicable to those cases in which the dyspnœa and cough continue during the day—I have used very successfully.—*Med. Record*, Dec. 7, 1889.

Shield (A. M.) on a Method of Local Medication in Perforative Otorrhœa.—The plan I call attention to is based upon a method of application of local remedies often adopted in other parts of the body. I allude to the employment of suppositories. In the present instance "pellets" would be a more satisfactory term. I have tried various sizes, but that of a swan-shot seems about the most generally convenient. These small round balls can be made of any size specified, and various drugs can be incorporated with the oil of theobroma which forms the basis, so that they quickly melt within the canal at the temperature of the ear. Up to the present time iodoform, boric acid, and tannic acid have been thus employed. It is obvious that any drug, anodyne or otherwise, could be similarly used and applied; morphine, for instance, in cases where pain is a prominent symptom.

The method of application is as follows: At night-time, the patient lying on the opposite side, one of the pellets is quickly taken up and dropped into the meatus. The tragus being drawn backwards and shaken, the little ball soon enters the canal. A plug of wool is then introduced, and the patient sleeps in the same position. The parts are thus for several hours impregnated with the agents introduced. The basis is soft, and so readily melts in the fingers that the pellets must be kept in a cool place, and rapidly dropped into the ear. Should they stick on the walls of the canal the point of a fine dry brush can be used to push them onward, and this instrument can be entrusted to unskilled hands.

I have employed these simple remedies in enough cases to convince me of their utility. Several students affected with otorrhœa have adopted the use of these pellets, and have spoken favorably of them. It must not for one moment be imagined that this treatment is to be regarded in the light of a specific for otorrhœa. New methods or remedies are too often adopted blindly in all sorts of unsuitable cases, and the results being disappointing they sink into undeserved oblivion. Oily applications of all sorts are apt to turn rancid, and cause clogging of epithelial debris and discharge. Accordingly the gentle and persevering use of the syringe is very essential, when oleaginous remedies are employed. In cases that can be seen and treated daily by the surgeon himself these remedies are not indicated; in other circumstances, and especially in out-patient practice, they will be found most useful adjuncts to cleanliness and ascepticism. Their composition and size can obviously be varied according to the case or the fancy of the prescriber.—*Practitioner*, Nov., 1889.

MEDICINE AND PATHOLOGY.

Pope (F. M.) on Thrombosis of Vertebral Artery Pressing on Glosso-Pharyngeal Nerve; Unilateral Loss of Taste at Back of Tongue.—S. K., aged seventy-six, a laborer, who had always enjoyed good health, felt weak on May 17, 1889. He fell down on getting out of bed on May 18th, but did not lose consciousness; after this he was unable to swallow any thing or to stand. There was no affection of speech, no pain in throat, no urinary trouble. He was admitted to the Leicester Infirmary on May 21st. He walked with much difficulty when supported by two persons. He was a large heavy man. The power of the left arm, hand, and leg was much diminished but not abolished. He was quite unable to swallow either liquids or solids. The house-physician considered that there was slightly less expression on the left side of his face than on the right, and that the right side moved more when speaking. This I could not see; at all events, there was far from extensive or general facial paralysis. The left pupil was much smaller than the right, and insensible to light. An œsophageal bougie or tube passed readily into the stomach.

On the next day, after he had been fed by the stomach tube, it was noticed that in addition to the expectoration of a very large quantity of frothy mucus, he regurgitated the greater part of the food that had been given him, also that the left side of

the soft palate was higher than the right. The tongue was protruded in a straight line. Suspecting interference with the glosso-pharyngeal nerve, I investigated the condition of his sense of taste. Two substances were employed: (1) a weak solution of acetic acid, and (2) simple syrup. The tongue was thoroughly dried, and a drop of each solution in turn placed on it with a glass pipette at four different points —namely, at back and front of each side of the tongue, about half to three quarters of an inch from the median line. Precautions were, of course, taken to thoroughly free the mucous membrane from one solution before applying the other. On the right side he tasted them well, and distinguished for himself between what he called the "sharp" and sweet tastes. He was told to signal with his hand the instant he commenced to taste, and his latent or conductive period was, as far as I could judge, rather short. On testing the left side, neither solution could be tasted at the back of the tongue; the acid was tasted at the tip of that side, the sweet solution not being perceived in the latter situation.

From the great contraction of the pupil, as well as the other symptoms described, it was thought probable there was a small hemorrhage into the pons Varolii.

On May 27th, though other symptoms were unchanged, he was weaker, and complained of pain on the left side of the head and face, but said that it was dumb to the touch. He could feel the prick of a pin well in the area complained of, but not stroking with a blunt instrument. After this he got rapidly weaker, and died on May 29th.

At the necropsy the left vertebral artery was found distended to about a quarter of an inch in diameter, and occupied by a firm clot for its whole course inside the theca vertebralis to its junction with its fellow of the opposite side. The enlargement was fusiform and regular; there was no sacculation. The brain was carefully examined and appeared normal. There was no valvular disease of the heart. All the other organs were healthy.

Here we have, I think, as clear evidence of the taste function of the glosso-pharyngeal nerve as could have been afforded by a precise laboratory experiment. The dilated artery pressed directly on the roots of the nerve, paralysis of which was shown by the loss of power of swallowing and the raising of the palate on the left side, due to the unopposed action of the levator palati. This is, of course, assuming that the glosso-pharyngeal is really the motor nerve of the palato-glossus and superior constrictor of the pharynx. The only other nerve involved was the pneumogastric, which cannot be supposed to have any influence on taste. The fifth was quite out of the region of pressure, as was the facial. The myosis and weakness of arm and leg on the same side as the tumor were doubtless due to deficient blood supply to the descending pyramidal tract on that side. The hypoglossal nerve, as evidenced by the tongue being protruded in a straight line, escaped pressure doubtless from the position of its roots on the opposite side of the artery to the two nerves already mentioned, namely, glosso-pharyngeal and pneumogastric. I am unable to account satisfactorily for the pain and dumb feeling on the left side of the face. There was not complete anæsthesia, and in fact little loss of sensation. The pain was not very severe, and did not follow the distribution of the cutaneous branches of the fifth nerve. The best suggestion I can make is that it was due to disturbance of the vasomotor nerves. I pass over the question of the cause of the thrombosis, which, though of considerable interest, does not affect the present question.

To conclude, loss of taste limited to the region of the tongue known to be the only part supplied by the glosso-pharyngeal nerve, with unmistakable *post-mortem* evidence of pressure on that nerve, leaves no room for doubt that, as has been usually held, the glosso-pharyngeal nerve takes part with the fifth in the taste function, and I would suggest also that the former is more directly concerned with the appreciation of sweetness, as even in the part supplied by the fifth on the damaged side, syrup could not be tasted.—*Br. Med. Jour.*, Nov. 23, 1889.

Goodell (W.) on the Abuse of Uterine Treatment through Mistaken Diagnosis.—In the first place, always bear in mind what another has pithily said, that "woman has some organs outside of the pelvis." Secondly. Each neurotic case will usually have a tale of fret or grief, of cark and care, of wear and tear. Thirdly. Scant or delayed or suppressed menstruation is far more frequently the result of

nerve-exhaustion than of uterine disease. Fourthly. Anteflexion *per se* is not a pathological condition. It is so when associated with sterility or with painful menstruation, and only then does it need treatment. Fifthly. An irritable bladder is more often a nerve symptom than a uterine one. Sixthly. In a large number of cases of supposed or of actual uterine disease which display marked gastric disturbance, if the tongue be clean, the essential disease will be found to be neurotic; and it must be treated so. Seventhly. Almost every supposed uterine case, characterized by excess of sensibility and by scantiness of will-power, is essentially a neurosis. Eighthly. In the vast majority of cases in which the woman takes to her bed and stays there indefinitely, from some supposed uterine lesion, she is bed-ridden from her brain, and not from her womb. I will go further, and assert that this will be the rule, even when the womb itself is displaced, or it is disordered by a disease or by a lesion that is not in itself exacting or dangerous to life. Finally, uterine symptoms are not always present in cases of uterine disease. Nor when present, and even urgent, do they necessarily come from uterine disease for they may be merely nerve-counterfeits of uterine disease.—*Med. News*, Dec. 7, 1889.

White (H.) on Symmetrical Intracranial Aneurisms of the Vertebral Arteries, Producing Symptoms Resembling Cerebro-Spinal Meningitis.—The patient was admitted for pain in the head, pain in the muscles at the upper part of the neck, retraction of the head, sickness, optic neuritis, paralysis of the left side of the face, paralysis of both hypoglossal nerves, hæmaturia, a mitral murmur, and a slight rise of temperature. The patient died in a fortnight. The diagnosis made during life was that he had cerebro-spinal meningitis, and that possibly this was due to ulcerative endocarditis. At the necropsy it was found that he had got ulcerative endocarditis, and that there was on each vertebral artery about half an inch from their junction an aneurism the size of a large pea; these aneurisms were the result of emboli. Each aneurism pressed upon its corresponding hypoglossal nerve, and thus explained the lingual paralysis. The facial nerves were not obviously pressed upon, but the aneurisms were so near them that it is quite possible that during life when distended they caused some pressure. The precise explanation of the retraction of the head was not evident. The base of the brain was covered with blood-clot due to the fatal rupture of the right aneurism. The retinal hæmorrhages and hæmaturia were embolic. Dr. White looked upon the aneurisms as due to embolism. He thought the ulcerative endocarditis was severe enough to cause the slight optic neuritis observed to be present. He was not able to determine whether facial spasm was present before the paralysis developed.—*Lancet*, Nov. 23, 1889.

Texas Fever and its Micro-Organism.—Dr. Theobald Smith of Washington, has made some preliminary observations on the micro-organism of Texas fever. Cultures have been made from the spleens of animals who died of Texas fever, and a variety of bacteria found. A variety of experiments led to the discovery of an organism within the red blood-corpuscles. The intra-globular bodies found are round or oval and nearly colorless. There is usually one, but two or more may be found in one corpuscle.

D. E. Salmon, D.V.M., Chief of the Bureau of Animal Industry, Washington, followed the reading of the paper by some general observations on Texas fever. The resemblance in the characteristics of yellow fever in man and Texas fever in cattle was noticed. Each disease has a permanently infected and well-known district which is its home. The contagion of both diseases is carried not by the sick, but by the healthy. Natives in the infected districts have a certain immunity from disease, while non-residents entering the locality will contract the fever. Both diseases, when carried north of their home, require a period of warm weather for development. Neither contagion survives a winter of snow and frost beyond its home. Both diseases are accompanied by an inflammation of the liver which causes yellow discoloration of the tissues, and in both hæmaturia is seen. These points of similarity may indicate that the germs have a similar nature, but the facts are given as a coincidence.—*Med. Record*, Oct. 26, 1889.

West (S.) on Gastric Ulcer Communicating with Colon.—A man, aged forty, was admitted August 15, 1889, presumably for intestinal obstruction, though there were no definite symptoms. Three years previous to admission, the patient

had been seized with sudden pain in the epigastrium, followed by vomiting. A week after admission he vomited some fæcal material, which led to a diagnosis of gastro-colic fistula being made, although no history of gastric ulcer had been obtained. The bowels were irregular, but there had been no obstinate constipation. On September 2d, Mr. Cripps saw the patient in consultation, and advised an exploratory incision being made. The operation was performed, but nothing was found. The patient died the following day. At the post-mortem examination, an ulcer of the stomach was found in the centre of a mass of medullary cancer which communicated with the colon. Dr. West remarked on the rarity of the pathological condition and on the clinical interest of the case, in that there had been a general absence of the symptoms of gastric ulcer, that there were no general signs of malignant disease, and on the uncertainty as to the duration of time of the existence of malignant disease of the stomach.—*Br. Med. Jour.*, Nov. 23. 1889.

Carter (R. L.) on Intra-Urethral Chancre, Causing Retention of Urine. — A man of twenty-seven presented himself at the out-patient department, complaining of inability to pass urine. He had noticed difficulty in commencing micturition for the last week, and for eighteen hours previously to his attendance at the hospital, retention had been complete. On examination, the bladder could be seen and felt as a distinct tumor, extending upwards nearly to the umbilicus. A small papular rash covered the thorax and abdomen. The lips of the meatus urinarius were everted and congested. Situated within the fossa navicularis could be felt an indurated mass, involving the whole circumference of the urethra. The dorsal lymphatic of the penis was thickened and indurated, and the inguinal glands on both sides enlarged and hard. There was no affection of the throat or other glands. A No. 3 silver catheter was passed without difficulty into the bladder, and the urine drawn off. The patient was directed to pass, by means of a probe, a strip of lint covered with mercurial ointment, through the indurated urethra every time after micturition, and mercury was prescribed by the mouth. The subsequent history of the case is without any special interest, no more difficulty with micturition being experienced. Absolute retention of urine from this cause is, I think, sufficiently rare to justify the publication of the case. — *Lancet*, Nov. 23, 1889.

TOXICOLOGY.

Adam (G. R.) on Iodism from a Single Intra-Uterine Application.— The intolerance of many patients of iodine in any form is an idiosyncrasy known to every practitioner, but it is usually after its administration per orem, and in the form of potassium iodidi, that unpleasant effects are seen in a typical manner.

A multipara, æt. 27, with a large, heavy, retroverted uterus, consulted me on the 10th of September. The uterus was straightened up, the sound entering three and a half inches, and a glycerine tampon applied; hot vaginal douches were also ordered. On the occasion of her second visit—some three or four days afterwards —I proceeded to make an intra-uterine application of Churchill's iodine formula: iodine 75 gr., potass. iodid. 90 gr., alcohol ʒ i., on a Playfair's probe, for the relief of the endometritis. Not much pain was complained of at the time, but on rising from the couch, the pain increased to such an extent that the patient had to again lie down and have hot poultices to the hypogastrium, and morphine freely given. In about two hours' time she had sufficiently recovered to be sent home in a cab, in charge of my nurse, who put her to bed and administered a half-grain morphia suppository.

On visiting her on the following morning I found her fairly free from pain, but suffering from well-marked iodism, suffusion of the eyes, coryza, etc., which subsided in a couple of days; but both upper eyelids were pigmented, and eventually desquamated. The pulse and temperature remained normal throughout, notwithstanding that the patient was excitable and restless.

It is somewhat remarkable that iodism should develop after so small a dose of the drug, and be so pronounced in its effects. The only reasonable explanation that presents itself to me is that, with a large retroverted uterus, the application caused violent spasm, which squeezed the iodine into the submucous tissue, where it has been rapidly taken up by the blood-vesssls, and

absorbed into the general circulation.—*Australian Med. Jour.*, Oct. 15, 1889.

Haley (R.) on a Case of Antifebrine Poisoning.—On October 28th I was hastily summoned to see a lady living about half a mile away, the messenger stating that "she was blue in the face, and seemed to be choking to death." The patient, a Mrs. S., æt. 28 years, mother of two children, the youngest æt. 13 months and still nursing, had been complaining of facial neuralgia for several days; she consulted a druggist and was given a large number of powders, each being about four grains, of antifebrine, with directions to "take one powder every two hours till easy."

She began taking the powders on the 25th, and kept on till the forenoon of the 28th. Feeling that the pain was rather worse than usual, she concluded to take the powders every hour. She took one at 11 A.M., and another at 12 o'clock. At 12:20 she fell out of her chair, while sitting by the stove, became unconscious, grew cold, purple in the face, and seemed to be choking, "like one with the croup," said a neighbor. The bystanders had given large quantities of strong coffee before I arrived. At 1 o'clock her temperature was 96.2°; pulse feeble and irregular, about 120; respirations 9 or 10; pupils slightly dilated; tongue dry and of dark bluish color, protruded with difficulty. The hot coffee had apparently revived her slightly, as she seemed to be conscious of what was going on around her, but could scarcely articulate the shortest words, saying "yes" or "no" only with an effort. The voice had a peculiar "croupy" sound. I administered stimulants freely, giving tr. capsicum and tr. ginger, along with brandy and alcohol.

In three hours the most of the symptoms had disappeared. The patient could talk, but said that her tongue was "stiff," and the skin all over her body felt numb; she said her hands and feet "felt like pieces of wood," but she could walk around the room with a little assistance. She said that in a very short time after taking the last powder violent pain came on in her chest, especially in the left side, extending in a few minutes to the stomach. Then she became chilly and could not move her eyes or her tongue, and her head felt as if grasped in a vise. She then became unconscious. She did not remember swallowing the first coffee that was given her, but her mother said that she swallowed what was poured into her mouth, easily. In four hours the temperature was 67⅘° F., and in ten hours it had run up to 102°. Next morning it was normal. She has had no appetite whatever since. The amount of antifebrine taken was about forty-eight grains a day for about three days—occasionally it seemed to relieve the pain, but not sufficiently to satisfy the patient. As I have known the woman for ten years, and never knew her to have any such paroxysms before, and as she is not hysterical, I think the antifebrine caused the train of symptoms above described. The application of mustard to the chest and stomach, and rubbing the extremities, seemed to give the patient nearly as much relief the first hour and a half as the internal treatment before mentioned.—*Weekly Med. Rev.*, Nov. 9, 1889.

MISCELLANY.

Gibney (V. P.) on the Treatment of Hip-Joint Disease.—The term hip-joint disease was, he thought, somewhat misleading. He looked upon it as a disease almost entirely of tubercular origin, and taking this view, we are greatly assisted in our management of these cases. Absolute and complete immobility of the affected joint was, he considered, the foundation for all treatment. An abundant supply of pure air, with good, wholesome nourishment, were most important factors in the treatment. He had not much satisfaction in the use of any of the splints devised for the treatment of this disease, but thought the perineal crutch useful in some cases. A plaster-of-Paris dressing extending from the free ribs downward, applied sufficiently strong to secure immobility, was necessary. There was no fear of trouble from anchylosis of the joint in these cases. In conclusion he related the different steps to be taken, should operation be found necessary.—*Med. Record*, Sept. 28, 1889.

Le Dentu on Artificial Opening for the Ureter in the Flank.—The operation was performed for compression of the ureters by a new growth, as death from anuria was imminent. The quantity of urine on the first day was 400 grammes. Later it reached 800, 900, and 1,400 grammes in twenty-four hours.

Death from cachexia occurred on the fourteenth day.—*L'Union Méd.*, Oct. 29, '89.

THE MEDICAL ANALECTIC

A WEEKLY EPITOME OF PROGRESS IN ALL DIVISIONS OF MEDICO-CHIRURGICAL PRACTICE

EDITED BY R. W. AMIDON, M.D.

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LEADING ARTICLES.

Evershed on a Case of Phthisis in which the Fatal Result was Due to Pulmonary Embolism.—This case is interesting as one in which pulmonary embolism probably caused death by asphyxia.

The symptoms here were more consistent with this view, and the extensive disease of the left lung made it probable that for some time it had been almost useless for respiratory purposes. As is well known, a portion of thrombus detached from a vein of the lower extremities is the commonest cause of pulmonary embolism. The conditions favoring the formation of such blood clotting were present in this patient, and the remains of a clot were found in the right femoral vein.

M. V—— was admitted in July, 1887. She presented the usual appearance of a person suffering from phthisis in its early stages. The account she gave of her family history was very indefinite—that is to say, it was impossible to fix an hereditary taint. She had been in good health until twelve months previous to her admission. Her illness began with a slight cold, with cough, etc. Apparently a bronchitis. She did not, however, improve under treatment, but gradually got worse, and eventually was admitted into the English hospital in Paris. During her illness she had cough all the time—often very troublesome at night. She had gradually lost flesh, suffered from increasing breathlessness, night-sweats, etc. She had always been able to take her food, and never had diarrhœa. Catamenia had been regular. On admission, she was tall, well formed, and stately in her carriage. Her voice seemed natural, but there was occasionally huskiness. Her complexion was dark, eyes black and brilliant, skin on exposed parts sallow and bronzed; where covered by clothing the skin was very fair, and when grasped had a peculiar limp and wet feel. The extremities of the fingers and toes were clubbed, and the lips had a bluish appearance. She became quickly breathless when moving about or exerting herself. Pulse was moderately full, soft, and rapid. On examination of the chest it was found well formed; there was, however, distinct flattening under the clavicles, especially on the left side. There was no expansive movement, the left side seemed almost fixed on causing the patient to inspire deeply; this want of movement was also to be felt; and while the hands were on the chest an increased fremitus was found on the left side. Comparing the percussion notes, a decidedly duller sound was elicited over the left side, and a *bruit de pot fêlé* was heard in the second left interspace. On auscultating, cavernous breathing, with large bubbling râles and pectoriloquy were found over the left apex, with fine crepitations in other parts of this side; the right gave exaggerated breath sounds nearly all over. Nothing abnormal was noticed about the heart sounds. The temperature rose to 102.4° in the evening. The urine had a specific gravity of 1010; there was no albumen. A simple acid mixture was prescribed; the sweats were checked with zinc and bella-

donna pills, and the temperature reduced with antifebrin.

Under the above treatment, with occasional mild counter-irritation, the patient progressed satisfactorily until the seventh week. There were some slight variations in the weight, but a steady increase on the whole. During the seventh week of her stay there had been some soreness of the throat, with hoarseness and increase of the fever. The parts were seen to be congested. The use of an astringent gargle relieved this, and she recovered her previous good condition, for during the subsequent week —viz., the eighth—she gained two pounds and a half in weight. Early in the following week—the ninth,—which was the last week of her stay, she complained of increased dyspnœa. This was aggravated at night. Under the influence of large warm poultices it abated somewhat. Nothing was found in the chest to account for the increased difficulty of breathing. On the following morning the dyspnœa was still marked, and she became suddenly very much worse. She was gasping for breath. No obstruction could be detected in the throat, and air seemed to enter freely. Stimulants were quickly administered, but without result. Within seven minutes from the time she was first seen she was dead.

At the necropsy, made twenty-seven hours after death, on opening the chest the right lung was found non-adherent, and, except for a few tubercles at the apex, seemed free from disease; it was paler than usual. The left lung was adherent all over; it was detached with difficulty from the side. When examined it was found solid and full of tubercles in the lower lobe and simply a multilocular cavity to represent the upper, the tubes containing purulent fluid wherever they remained. The heart was soft and flabby, and, as usual, covered with a soft fat. On opening it, clots were found in all the cavities; the right side was full of a dark clot, which extended to the bifurcation of the pulmonary artery and along the right branch of that vessel, completely blocking it. On breaking through this soft clot a long, branching, and firm worm-shaped clot was found passing along the pulmonary vessel.

Here, then, was the cause of death. The plug existed in the only sound lung. Hence when the vessel was completely blocked death was almost instantaneous. The occurrence of death from this cause in cases of phthisis is not common, though cases have been reported. In this case I believe the clot came from the veins in the right leg, as on opening up the inferior cava some small firm masses were found, and these were also found in the femoral vein. —*Lancet*, Oct. 26, 1889.

Sangster (J. I.) on Infectious Pneumonia.—During the winter of last year a series of cases occurred in my practice, which to me were of a very unusual character.

W. H. P——, aged thirty-four, a strong, healthy man, a total abstainer, consulted me on July 19, 1888, for what he supposed to be a cold. He had been ailing for a day or two, and complained chiefly of headache, muscular pains, and loss of appetite; there was a slight rise of temperature. On the 22d I visited him at his home. I learnt that on the two previous days he had been so unwell that he was obliged to remain in bed. The symptoms were much the same, but the headache was more severe. I noticed that there was a spasmodic cough; the temperature was 102°.

From this date to the 26th the condition was becoming worse; delirium of an active character had appeared, and was tolerably constant; the cough continued, but several examinations of the chest up to this time failed to discover any thing abnormal; the abdomen was somewhat tympanitic; the temperature had reached 105°. No rose-colored spots were discovered.

On the 27th, *i.e.*, eight days after the patient was first seen, signs of pneumonia were found at the base of the right lung. From this time the disease ran a rapid course; both lungs were soon involved; there was now very little cough; expectoration was slightly rusty and very scanty; his appearance was very cyanotic.

Death occurred on the evening of the 31st, *i.e.*, fourteen days from the outset of the illness, four days after the discovery of the pneumonia. The diagnosis was enteric fever, complicated by pneumonia.

For special reasons a post-mortem examination was obtained. No intestinal lesion was discovered; the spleen was of normal size; both lungs were extensively hepatized; there were no signs of pleurisy.

Pneumonia was obviously the cause of death.

The same day that I first visited W. H. P——, I was requested to see his sister,

Mrs. D——, aged thirty-six, who lived in the adjoining house. I learnt that she had been ill since the 18th, that was just about the time of the onset of her brother's illness. She had severe headache, pains in the limbs, some cough, and was very prostrate; these symptoms, together with some distension of the abdomen and relaxed bowels, led to the suspicion of typhoid. On the 25th inst., *i.e.*, seven days after the commencement of the illness, pneumonia, which previous examinations had failed to discover, was detected at the base of the right lung; some characteristic sputa were noticed on this date.

The patient, who was extremely prostrate from the beginning, sank rapidly and died on the evening of the 26th. The temperature an hour before death was 108°.

On July 25th, I was requested to see Miss A. P——, aged twenty-five, sister of the previous patients. She lived in the same house with Mrs. D——. She had been unwell for a day or two, complaining chiefly of dizziness, moderate headache, and muscular pains.

These symptoms, with a somewhat characteristic temperature, led to the diagnosis of typhoid. On the 30th, *i.e.*, five days after I first saw the patient, seven or eight days from the commencement of the illness, I noticed that the breathing was abnormal; there was no cough, nor had there been any from the first. I found some dulness, with bronchial breathing below the left scapula. On the 31st, dulness and moist sounds were noticed in both lungs. The abdomen was tympanitic; no spots were discovered.

The disease in this case ran a much less rapid course than in the other patients; there was scarcely any cough all the way through; expectoration was almost absent.

During the last few days of her illness there was active delirium. She died on the afternoon of the 7th inst.

The original diagnosis of typhoid was concurred in by two consultants.

This diagnosis was disproved by the autopsy, and the series, considered as a whole, require other interpretation.

Pneumonia in the ordinary form must be left out of consideration, as must also what is known as epidemic pneumonia, which is simply an unusual prevalence of the croupous variety.

Viewing the cases from beginning to end, I cannot but think that they were the outcome of some very unusual morbid agency, the lung being specially selected for attack in the later stages of the disease.

As to the actual causation, I can advance no opinion. I may mention that at the time when these cases, which naturally caused a good deal of excitement, were going on, a rumor was circulated that cattle suffering from pleuro-pneumonia were in the hands of the local butchers. The inference was that diseased meat was being vended. The evidence as to the purchase of diseased animals was conclusive, but the sale of the meat could not, of course, be proved. Veterinary pathologists do not condemn the meat in the earlier stages of the disease, but in the more advanced stages they state that the muscular tissues are affected and quite unfit for use.

Does cooking in all cases do away with the risk of using diseased food of any kind?

A temperature of 212° F. (boiling-point) is said to be fatal to most micro-organisms, but the spores of bacillus anthrax are not killed in less than three hours by a temperature of 284° F. It is open to question whether the process of cooking is so universal a safeguard as it is supposed to be.

The treatment of these cases was conducted on ordinary principles.—*Australasian Med. Gaz.*, Sept., 1889.

MEDICINE AND PATHOLOGY.

Diabetes Mellitus in a Child Five Years Old.—D. B. K. Rachford, of Newport, Kentucky, reports a case of precocious diabetes.

The child's symptoms were emaciation and loss of strength. Later, an unusual appetite and thirst came on with polyuria, six or seven quarts of colorless urine with a sp. gr. of 1,035, containing a large amount of sugar. Medical aid was not sought until July 25th, when the child was given fl. ext. ergot and diabetic diet. Death took place four days later.—*N. Y. Med. Jour.*, Dec. 7, 1889.

Atrophy of the Pancreas and Diabetes.—Professor Lépine, of Lyons, is studying the relation between diabetes and pancreatic lesions. M. Lancereaux is the first Frenchman who studied the question, and affirmed that atrophied pancreas

and diabetes are coexisting. Numerous clinical facts ratify this belief, and lesions of the solar plexus concomitant with those of the pancreas are supposed to determine diabetes. Laboratory experiments indicated that with atrophied pancreas urine would be free from sugar. Arnozan and Vaillard tied the pancreatic duct in a rabbit; there was absence of sugar in the urine. In the course of this year two physiologists at Strassburg have repeated these experiments, and have observed that, on removing the pancreas from a dog, sugar appears in the urine. M. Lépine's experiments furnish the same results; the first dog under experiment survived the removal of the pancreas seventy hours; during these seventy hours it refused all nourishment; it lost 20 per cent. of its weight, 37 grammes of urea, and 54 grammes of sugar, which appeared in the urine a few hours after the operation, and gradually increased until death took place. The second experiment confirmed the first; in this instance the animal was rendered unconscious by morphine; in some of the dogs the pancreas was not entirely removed; these furnished negative results. At the necropsy it was seen that eight grammes of pancreas remained.—*Br. Med. Jour.*, Nov. 16, 1889.

Reflex Nervous Phenomena Due to Preputial Contractions.—Dr. R. W. Bruce Smith, of Seaforth, Ont., narrates three interesting cases.

In two boys, of five and eight respectively, great irritability, fretfulness, and some convulsive movements were coexistent with phimosis and preputial adhesions, and disappeared after removal of the apparent cause.

In a third case, a boy of three and one half, fretfulness merged into convulsions, and a gradual disinclination to walk, which later took the form of a spastic paraplegia. Removal of preputial irritation relieved symptoms and resulted in a final cure.—*Canada Lancet*, Dec., 1889.

Tetanus Following Typhoid Fever.—A boy of eighteen was admitted to the hospital July 12th, suffering from typhoid fever. On Aug. 16th the temperature fell to the normal, and on the 28th, although very weak, the patient got up.

The attending physician, Dr. McDonnell, was sent for, as the patient was seized with convulsions. These were typical tetanic convulsions: trismus, risus sardonicus, and opisthotonos. Twenty-five of these attacks occurred in twenty-four hours. Urethane was tried in gr. xx. doses every two hours, but seeming to do no good it was given up, and chloral was ordered, gr. xxx. every three hours. The patient was discharged cured in ten days.—*Australasian Med. Gaz.*, Oct., 1889.

Cumulative Constipation. — Dr. Henry M. Field, of Newton, describes two kinds of this ailment: one in which the intestines, irritated by impacted fæcal matter, pour out a secretion which finds its exit and gives rise to a false diagnosis of unnatural looseness of the bowels; and another variety of the disease, where incomplete evacuations gradually allow the bowels to fill up with impacted fæces.

In such cases the author advises a compound rhubarb pill every hour, telling the patient that fifteen or twenty pills may be needed. In very obstinate cases enemata with a rectal bougie may be needed.—*Boston Med. and Surg. Jour.*, Nov. 28, 1889.

Putnam (J. W.) on Abdominal Dropsy in a Young Subject.—A boy, eleven months old, with acute general dropsy. The scalp, hands, arms, legs, and ankles all pitted on pressure. The abdomen was greatly distended with fluid. There was no history of previous ill-health. The bowels moved naturally every day. There was no suppression of urine. There had been no cutaneous trouble.

Small powders of jalap and cream of tartar were prescribed. These operated freely, and reduced the œdema of the extremities to a marked extent. The ascites, however, was diminished and we accordingly decided to tap. We drew off one pint of fluid, which was straw-colored, and did not differ from the usual ascitic fluid. The child made a complete recovery.—*Buffalo Med. and Surg. Jour.*, Dec., 1889.

Kerr (W. W.) on an Interesting Case of Vicarious Hemorrhage.—A married woman, forty-two years of age, came under my care in March, 1888, suffering from a rheumatic affection of the knee-joint. The following June she began to suffer from headaches and intense pain in the epigastrium just before the menstrual period, these symptoms invariably disappearing upon the appearance of the menses. From August, 1888, to July, 1889, inclusive, the gastric pain was accompanied by hematemesis and a most

intensely irritable stomach, so that not even the smallest quantity of fluid or solid food could be tolerated. With the appearance of the catamenia, all these unfavorable symptoms vanished, leaving only some slight tenderness on pressure over the epigastrium. In August, 1889, the hematemesis was replaced by epistaxis. In September there was no vicarious hemorrhage, but so profuse menorrhagia that it became necessary to tampon the vagina and the cervical canal. Repeated examinations failed to discover any morbid condition of the uterus or its appendages.

During the months that the patient was under my care every remedy was tried for the relief of the gastric symptoms, without producing any beneficial effect, but when the menses appeared she would, within a few hours, feel perfectly comfortable. The relation between the gastric symptoms and the menstrual flow was curiously demonstrated at one time, when, owing to the inattention of a nurse, the menses were arrested a few hours after their appearance. On this occasion the gastric disturbance returned with such intensity as to seriously endanger the life of the patient, and then as rapidly disappeared when the flow had been re-established. This attack so exsanguinated the patient that removal of the ovaries was seriously contemplated in the event of its recurrence, but her gradual improvement from that date, and the natural proximity of the menopause, deterred us from undertaking the operation. The only way in which the catamenia could be established was by the persistent use of hot poultices and hip-baths.

In every other respect the patient was healthy. Prior to this attack she had not suffered from the slightest gastric disturbance, and therefore it is highly probable that the gastritis which subsequently developed was a result of the repeated and prolonged monthly congestions of the stomach, a similar affection of the uterus being obviated by the separation of the lining membrane, which takes place with every period. The disease can only be regarded as a neurosis, leading to vasomotor disturbance, so that the monthly congestion takes place in some other organ than the uterus, and in the majority of cases the uterus and the organ from which the hemorrhage takes place will be found free from any morbid anatomical change.

Of course it is perfectly possible to contemplate the existence of an anatomical change in the uterus incapable of clinical demonstration, yet sufficient to obstruct the menstrual flow—such as abnormal thickness of the lining membrane, or failure of the same to undergo the periodical monthly degeneration; but while such changes might explain the absence of catamenia, they will not account for the *local* rise in blood pressure which terminates in hemorrhage from a previously healthy organ. The change in the source of the hemorrhage in the same patient, which is so frequently observed, as in the case reported, where it came from the stomach one month and from the nose during the following month, is sufficient proof that there is a point of local intensity in the rise of blood pressure, and that the hemorrhage is not due merely to a general rise in pressure finding relief at the point of least resistance.

To us, therefore, the most satisfactory view of vicarious hemorrhage is to regard it as the result of a neurosis, manifested through the agency of the vasomotor system, by which there is: 1. A spasm of the uterine vessels, retarding or arresting the menstrual flow. 2. A rise of blood pressure, having its local intensity in the organ from which the hemorrhage takes place.—*Occidental Medical Times*, Dec., 1889.

Hæmophilia.—Dr. Fischer of Munich describes a large family all the members of which had suffered more or less from hæmophilia. The family was very prolific, the members living to various ages. One child died at nine months, one man at sixty-two years, and two others at sixty-seven are still alive. The proportion of females to males is four to thirteen. The bleeding takes place chiefly from the nose and gums, and the loss from these parts is very heavy; but bleeding from the internal organs is rare. The author, having found that in patients suffering from hæmophilia the proportion of red blood corpuscles to leucocytes is 1500 to 1, believes that the disease consists essentially in an alteration in the quality of the blood as well as of its quantity. He considers the disease to be caused by increased activity of the blood-making organs and their increased capacity for forming red blood corpuscles. On this theory it is, as the author shows, possible to explain most of the symptoms of hæmophilia. Latency and paroxysms are the

different stages of the disease. The alteration of the blood is naturally followed by an alteration in the functional activity of the various tissues. Hyperæsthesia of the whole nervous system and of some centres in particular, and an alteration in the elasticity and contractility of the blood-vessels, and in the density and firmness of their walls, are observed. Functional hypertrophy may arise from the increased resistance of the heart, the quantity of the blood being also abnormal. The author considers the frequent rheumatism and neuralgic symptoms in the bones and joints as equivalent to hæmophilous bleeding. Both serve the purpose of eliminating superabundant blood.—*Lancet*, Nov. 23, 1889.

Horne (A. J.) on the Inflammation of the Breast and its Treatment by Elastic Pressure.—The author has arrived at the following conclusions from his experience in the management of the puerperal breast:

1. Mastitis is rarely seen, except in patients who have suffered from fissured or crushed nipples, and is the result of infectious matter gaining entrance.

2. That, as a rule, the secretion of milk continues only while the natural stimulus, as nursing or other means, continues to be employed.

3. That the secretion of milk, either in normal or inflammatory state, begins to abate when such stimulus is withdrawn, and will entirely cease after a week or two.

That in all cases of threatened or inflamed breast, well regulated pressure by means of an elastic bandage should be applied, and no attempt should be made to nurse or withdraw the secretion until the entire subsidence of the inflammatory movement.

The advantages of the elastic bandage over an ordinary roller are: 1. It is easier of application. 2. The pressure is more uniform. 3. It is not so likely to slip. 4. It is more comfortable to the patient, as requiring much less material. 5. It is not necessary to apply it over the shoulders.—*Dub. Jr. Med. Sci.*, Nov., 1889.

Inglott (G. F.) on Human Milk of Low Temperature.—On September 29, 1885, Mrs. M. came to my consulting-room stating that her child, six months old, refused ten days ago to take her right breast. After inquiry I found that the patient, aged 35, and strong in constitution, had suffered at the age of 20 years from severe hysterical fits of convulsive and non-convulsive form, which lasted for a long time. Her menses commenced at the age of 15, recurring regularly every month and were rather profuse, lasting about eight days each time. She had seven children, of whom six were alive and of good constitution. As to her parents' history, I could only gather that her mother died of cancer of the uterus. There was no history of syphilis in the family.

On examining the milk I was highly surprised in finding it as cold as iced water. I was much interested in the case, and, after careful consideration, I came to the conclusion that it was a nervous phenomenon due to the hysterical state of the woman. I prescribed, therefore, one drachm of bromide of potassium daily in a decoction of cinchona bark, and a mixture with camphor and valerian. After ten days' treatment the milk acquired its normal temperature, and the child began to suck the breast again.—*Br. Med. Jour.*, Nov. 30, 1889.

THERAPEUTICS.

Uræmic Convulsions Controlled by Morphine.—The almost universal but unjust prejudice against the use of morphine in *all* uræmic conditions, receives another refutation in the report of a case by Dr. F. J. Bowles, of New York City. A girl of thirteen had headache, puffiness of the face, and great irritability for a few months, and was thought to be suffering from malaria. The urine was found highly albuminous, and an effort was made to increase the activity of the skin, bowels, and kidneys. In spite of this convulsions came on at the rate of 12 in 16 hours. The pulse was uncountable, the respiration shallow and irregular. A hypodermic of morphine and atropia stopped the convulsions, quieted the pulse and respiration, and induced a copious flow of urine. Complete recovery followed.—*Med. Record*, Dec. 7, 1889.

Haig (A.) on the Influence of Opium and Morphine on Uric Acid Considered with Reference to their Action in Health and Disease.—A large number of drugs—iron, lead, the mineral acids and their salts, antipyrin (?), nitro-glycerine (?)—have one effect in common, namely, that of diminishing the excretion of uric

acid in the urine,—that is, I believe, driving it out of the blood into the liver, spleen, joints, etc. Exactly contemporaneously with the diminished excretion of uric acid due to any of these drugs comes a fall of pulse tension, and a mental condition of brightness and well-being. Uric-acid headache and mental depression, if present, are cured, and in their place come pricking and shooting pains in the joints, most marked in those who have previously suffered with gouty arthritis. On the other hand, an alkali, as soda or potash, while increasing the excretion of uric acid, produces symptoms which are the exact reverse of those above mentioned. As these drugs have no obvious properties in common, I have inferred that the results they produce are due to their action on uric acid. Opium and morphine, as we have seen, diminish the excretion of uric acid, and at the same time reduce pulse tension, cause mental brightness and well-being, cure a uric-acid headache, and cause at the same time pricking and shooting pains in the joints; they, therefore, belong to the iron, lead, and acid group of drugs with which their effects exactly correspond, and as they always cause a marked rise of the acidity of the urine, I conclude that their action on uric acid is the result of their action on acidity.

I have shown that morphine, probably by acting on uric acid, relieves or removes high-tension pulse, mental depression, and headache.

It has been noticed that morphine is of much use in certain uræmic and puerperal convulsions which are generally accompanied by a high-tension pulse. I now suggest that its curative action in these troubles is also due to its effect on uric acid, and that further investigation may show that these convulsions, like some of those in ordinary epilepsy, have a more important relation to the excretion of uric acid and its effects on pulse tension than has hitherto been suspected.—*Br. Med. Jour.*, Nov. 30, 1889.

Draper (W. H.) on the Relation of Diet to Uric-Acid Formation.—The author thinks: 1st. That deposits of uric acid and its compounds in the urine do not necessarily indicate so much any considerable increase in the formation of this substance as they do a condition of the blood which affects its solubility and the facility of its excretion. 2d. That this condition of the blood is one of diminished alkalescence. 3d. That this diminished alkalescence is produced by the entrance of acid substances into the circulation, largely through the fermentation in the alimentary canal, or the imperfect conversion by the liver of the saccharine and farinaceous elements of the food. 4th, and finally, that clinical experience, which, after all, in the present state of our knowledge of the chemistry of digestion, is our best guide, tends to show that the withdrawal, more or less complete, of the non-nitrogenous foods, and the allowance of a larger admixture of the nitrogenous elements, constitute the most efficient means of controlling the formation and excretion of uric acid and the protean functional and tissue derangements which belong to the lithæmic state.—*Med. Record*, Oct. 12, 1889.

Treatment of Gonorrhœa. — Dr. Ryan-Tenison having cured a case of gleet, which had resisted treatment by nitrate of silver, thallin ointment, and sandal-wood oil, with sodium salicylate, successfully employed the remedy in an acute case in conjunction with injections of permanganate of potassium (gr. x. to ʒ i.).

Dr. James MacMunn in similar cases uses oil of peppermint and carbolic acid.—*Br. Med. Jour.*, Nov. 16, 1889.

Medicinal Treatment of Retention of Urine from Prostatic Enlargement.—Dr. Hugh Woods writes to the *Br. Med. Jour.*, Nov. 23, 1889, as follows: I do not now remember who first recommended the use of liquid extract of ergot in these cases, but it has been recommended for prostatic enlargement, and is, in my opinion, deserving of much more extended use for this condition. The mixture which I am in the habit of using contains in each drachm: ext. ergot. liquid., ♏ 7½; tinct. belladonnæ and liq. morphinæ āā, ♏ 3½, with magnes. sulph., etc. I have repeatedly found this mixture most efficacious in relieving retention of urine in cases of enlarged prostate, obviating the use of the catheter with its attendant risks, and removing all urgent symptoms for a considerable period. Medical friends of mine who have tried the above mixture have obtained results as good as my own. Probably the ergot is the important remedial agent, but the above formula seems to give the best results. It should be given in ʒ j. doses, or more, in water. I certainly think that there is a large class of cases of re-

tention of urine, from enlarged prostate and other causes, in which some such medicinal treatment is decidedly preferable to the use of the catheter or other surgical interference.

Creolin in the Cystitis of Women.—Dr. Parvin, of Philadelphia, highly recommends an injection of a ½ % mixture of creolin in water in the cystitis of women. He formerly used a much stronger mixture, which, while the ultimate results were good, caused violent local suffering lasting several hours. Some means of causing the drug to be more miscible with water, and at the same time not lessen its antiseptic power, would be very acceptable.—*Medical News*, Nov. 30, 1889.

Lesser on Insoluble Mercurial Injections.—Among 500 injections of such substances (calomel, hydrargyrum oxydatum flavum, hydrargyrum salicylicum, tannicum, gray oil) intestinal disturbances and dysenteric conditions had occurred twelve times. In three cases symptoms of embolic pulmonary infarction supervened immediately after the intra-muscular injections. The symptoms were irritative cough, cyanosis, and pains in the back. These conditions were probably to be explained by the fact that the bulk of the injection had penetrated into one of the large veins. The danger in the case of injection of insoluble salts of mercury lay in the fact that a deposit of mercury was established in the body, from which it penetrated slowly, but constantly, into the organism. Furthermore, in the case of the occurrence of poisoning, the conveyance of mercury to the organism could not always be immediately discontinued, as, for instance, in the case of the inunction cure, or in that of the administration of soluble mercurial salts.—*Br. Med. Jour.*, Nov. 9, 1889.

Stoker (W. T.) on the Treatment of Acute Intestinal Obstruction due to Collections within the Lumen of the Bowel.—The author states that local treatment calculated to irritate the abdominal wall or produce rubefaction is calculated to do harm, and that only soothing and emollient applications should be employed. Opium should not be generally or incautiously employed, as it is capable of being a most dangerous agent. Pressure and massage may help, particularly if employed early. While purgatives can only be sources of danger when the obstruction is seated in or external to the wall of the bowel, they may be employed with freedom in intramural obstruction, and should, if used, be used actively and for a short time only. Belladonna in large doses is a most powerful agent. Tapping the bowel for meteorism is safe and useful. The full value of an enema can be got by the use of a short tube, while a long tube is dangerous.—*Dublin Jour. Med. Sci.*, Nov., 1889.

Poisoning by Gasoline.—Dr. J. G. Biller reports two cases of poisoning by drinking gasoline, in children under two years old. The symptoms in each case were very similar—speedy loss of consciousness, very faint pulse, slow gasping respiration, lividity of the face and extremities, eyes rolled back, pupils dilated, jaws rigid, abdomen distended, surface cold and clammy.

The symptoms in the first case, seen in ten minutes, were relieved by a hot bath, but the child suddenly died. In the second case, which was seen in less than three minutes, recovery supervened. Ipecac was given by the mouth, digitalis and brandy under the skin. The stomach was thoroughly washed out, but the most good seemed to accrue from the inhalation of amyl nitrite.—*N. Y. Med. Jour.*, Nov. 30, 1889.

SURGERY.

Ryan (G. W.) Discussion on Tubercular Disease of Bones and Joints.—One method of treating the disease when it occurs in the lower extremity has been so identified with this country that it has been known as the American plan. This is the method by extension and fixation, or extension with motion and the use of the hip splint. It has had a twenty years' trial, but the results are not as satisfactory as they might be—not even in the hands of the most skilled, and under the best conditions. It is believed that the surgical mind of the present day is about convinced that the best treatment for joint disease lies in the principle of rest as embodied in fixation—without joint traction or extension. The method that approaches this is that known as Mr. Thomas' treatment. It consists of fixation by means of a simple splint. The results, as reported to us, are most excellent ones, and his statements are substantiated by those who have seen his work.

It has been shown that a healthy joint can be confined for months and yet retain mobility. The great desideratum is rest, and the question of its most advantageous application is for the surgeon to determine. —*Cin. Lancet-Clinic*, June 22, 1889. J. R.

Hoadley (E. A.) on Tubercular Joint-Disease.—The operative indications are discussed, and two cases narrated.

In conclusion, I wish to emphasize that early, thorough, and repeated aseptic operation is the treatment for this class of cases. There is at present but one fixed rule in regard to operation, and that is to remove all the diseased tissue in whatever structure it may exist, and sacrifice nothing—that is, remove no healthy tissue, bone especially—without it is unquestionably in the way and liable by its presence to interfere with obtaining the best results. Excisions of joints, as a rule, are objectionable, because of the unnecessary amount of healthy bone removed. Complete enucleation of the synovial membrane, together with such diseased portions of bone as may exist, give the best results, and the operation should be repeated as often as it becomes evident the disease is still in progress.—*Medical Age*, Aug. 20, 1889. J. R.

Petersen, of Kiel, on a Neuralgic Affection of the Knee.—The author has treated a patient presenting all the symptoms of an articular affection of the knee, with intense neuralgic pains accompanied by fever. Massage had been employed with negative results. He placed a plaster bandage, which he allowed to remain in position for ten months and a half, after which time he took away the bandage and allowed the patient to walk about; pain soon returned, accompanied by swelling and fever. He then decided to have recourse to an operation, but found nothing abnormal in the peri-articular tissue nor in the synovial membrane. The patient was cured without any rise of temperature, and presented after the operation symptoms of hyperæsthesia, which she had never felt before, besides other hysterical phenomena, but the articular pain had disappeared.

Prof. von Esmarch has observed a case of neuropathic coxalgia in an hysterical woman, who presented all the symptoms of hereditary tuberculosis, and even had tubercular glands, with fever in the evening. He tried five times to immobilize the parts with a plaster apparatus, and five times the pains and fever disappeared, but the affection would return as soon as the apparatus was removed. He then decided to open the articulation, but found no traces of inflammation, all the articular tissues being healthy. Cure was rapid; fever disappeared, and to-day the patient walks perfectly well, without any pain.—*Med. News*, Jan. 1, 1889. J. R.

Landerer on Dry Operations.—His reasons for rendering operations as dry as possible are not without weight. He points out that the employment of all sorts of antiseptics may be dangerous under certain conditions, and that it is advisable to avoid them as much as possible. The employment of sterilized fluids in large quantities is inconvenient and messy, and there are many advantages in keeping the field of operation quite dry. The essential part in the dry method is immediately after the first incision to keep every part of the operation field, not for the moment under the knife, under pressure by means of antiseptic gauze, dry sublimate gauze is what he recommends. By this means the wound can be closed more quickly as the plugging will have arrested the bleeding, and drainage will frequently be avoided altogether. The suturing then takes place, after which a moderately firm compress is applied. In this way the patient is less messed and cooled, there is less loss of blood, and above all no germs can enter from the moment the plugging is applied. The bleeding is more quickly arrested, and the duration of the operation is shortened, whilst at the same time healing is rendered more rapid and certain.—*Med. Press*, Nov. 13, 1889.

Barnes (A. R.) on an Unusual Dislocation.—At midnight, on June 12th, a man was brought to my house, who, as he expressed it, "had turned his foot round." He was able to hobble in, and could bear a little weight on the injured foot. On examination his foot presented a most curious aspect; it was, as he had described, turned completely round; the posterior aspect of the os calcis passed from under the articular surface of the tibia, and the whole foot pointed in directly the opposite direction to that it should have done. About three inches of the fibula, which were broken off, were twisted behind the tibia. Reduction was effected

by a moderate amount of traction accompanied with a rotatory movement, the foot coming into a right position with a rather unpleasant sort of scrunching sensation. The application of splints completed the treatment. The accident was caused by the foot slipping when carrying a bag of meal on his back.

Dislocations of the ankle are not common. This, I apprehend, was an exaggerated form of the outward dislocation.—*Br. Med. Jour.*, Oct. 12, 1889.

Beasly (G. F.) on a Convenient and Comfortable Dressing for Fracture of the Bones of the Hands.—It is a well-known fact that the best results in the treatment of fracture are obtained when the injured limb, after the reduction is accomplished, is placed in the position it naturally assumes when at rest. Hence, one of the most comfortable as well as convenient dressings of the fractured humerus is the Stromeyer pillow, filling as it does the angle between the chest and the arm. The hand, when at rest, is flexed and the palmar surface is concave in all directions. Acting on this hint, I have been using for some time in fractures of the hand, for a palmar splint, an ordinary rubber ball. Plug the opening, and if the ball does not completely and snugly fit the flexed hand, cover it with absorbent cotton, jute, or, what is better, marine lint.

Then, after putting the fractured bones in proper position, place the ball in the palm and flex the fingers and thumb around it; then using a roller about one and a half to two inches wide, snugly bandage them in place. At first I used a dorsal splint of gutta-percha or card-board.

The advantages of this dressing over the straight splint are: It is more comfortable and more easily borne; is not inconvenient and in the way as when a finger is extended and rigid, catching on every obstacle and rendering life a burden to the sufferer.

In case there is partial anchylosis it is much easier to restore the function of a flexed finger than an extended finger, and if there should occur complete anchylosis, the flexed condition is not a serious hindrance in labor.

In some cases there is more or less comminution and slight overlapping. The bow, if any occurs, will be on the dorsal instead of the palmar surface, and will not impair the flexing of the finger.

If only the ulnar side is injured the dressing can be so applied as to leave the thumb and index finger free, and if it is the right hand, the sufferer can use the hand in writing, eating, etc.—*Am. Pract. and News*, Oct. 26, 1889.

Jessett (F. B.) on Excision of the Entire Clavicle for Large Subperiosteal Sarcoma.—The patient was a young woman of sixteen years. Over the inner two-thirds of the right clavicle there was a growth, circular, five inches in diameter, one and a half years' duration. The arm on the affected side was somewhat œdematous. Diagnosis of sarcoma having been made, the clavicle was excised through an incision running its entire length.

The patient made a rapid recovery, and two months after the operation the movements of the arm were nearly complete.—*Lancet*, June 1, 1889. C. A. P.

MISCELLANY.

A Uretro-Uterine Fistula.—Our Austrian correspondent records what is probably an unique case of uretro-uterine fistula in a young woman who was delivered of her first child by means of the forceps. Soon after delivery a watery discharge, having the characters of urine, was noticed coming from the vagina, but beyond a laceration of the cervix, the closest examination failed to reveal any thing in the nature of an urethral or vesical fistula. Milk was injected into the bladder, but did not appear in the discharge, and for a time the surgeon under whose care she had been, was extremely puzzled to account for the phenomenon, the more so as the patient passed water at least twice a day *per vias naturales*. The uterus was then dilated, and a round, smooth swelling was seen projecting from the left wall, from which the watery discharge appeared to be oozing. The next step was to dilate the ureter, and introduce a vesicoscope, when it was remarked that the urine flowed into the bladder only from the left ureter, the right appearing to be blocked. An attempt was made to pass a sound into the right ureter, but it could not be made to penetrate more than about three quarters of an inch. Four weeks later the right kidney was removed and the ureter ligatured. The wound healed by first intention, and the patient was able to leave the hospital at the end of three months,

but some slight discharge from the uterus still persisted. The kidney proved to be enlarged, and showed signs of a commencing pyo-nephritis, and the ureter much dilated. These cases are extremely rare, only ten others being on record.—*Med. Press*, Nov. 20, 1889.

Stone (I. S.) on the Treatment of Contracted Bladder by Hot-Water Dilatation.—During the past few years certain protracted cases of cystitis, occurring chiefly in women, have been observed by Dr. Stone, which have resisted all known forms of medical treatment, and necessitated some surgical or mechanical measure of relief.

He describes the manner of dilatation as follows: The patient is given morphia sulphus.(gr.$\frac{1}{4}$), atropia sulph.(gr.$\frac{1}{100}$), hypodermically. She is placed on her back on a table for convenience (although it would answer to arrange the bed with the patient thereon to suit the operator). A soft catheter is at once inserted into the bladder, and after the urine has escaped hot water (temperature 110° F.) is thrown into the bladder, until the patient will no longer bear it. This is allowed to escape, and is measured, giving the full size of the bladder in its present condition. As the morphia gradually becomes absorbed the patient will bear still farther distention—each time perhaps one drachm may be added to the capacity of the bladder. I prefer using a rubber-ball syringe, holding two to four ounces. The pressure of the hand is safer than that of the tube or funnel, or any instrumental gauge, as the patient generally is unable to resist the tendency to strain, owing to tenesmus produced by the expansion. As each séance should continue thirty to sixty minutes the bladder may be filled and emptied many times, and at first the operator must be well satisfied if the gain is only one or two drachms, in a bladder whose capacity is perhaps only two ounces. As the patient becomes fully under the influence of the morphia, the water may be increased in temperature to 120° or 125° F. The very best effect follows its use when at this temperature.—*Med. Record*, Dec. 7, 1889.

The Treatment of Diphtheria.—A family of two children with their parents fell ill one after the other with diphtheria. The father, a medical man, adopted Dr. Gaucher's treatment, which is as follows: a tampon of cotton-wool steeped in the following solution is applied every two hours inside the throat, pressing slightly on the false membranes: 10 grammes of alcohol, 15 grammes castor oil, 5 grammes carbolic acid. The false membranes become desiccated and roll up; it is then easy to remove them. After they are taken away, the solution need be applied only once a day. Adults during the treatment gargle their throats with a weak solution of boric acid; with children, an irrigator or spray must be used. M. Hertinel slightly modifies this treatment; he uses 25 grammes glycerine, 20 camphor, 5 carbolic acid, and uses a spray of boric acid in weak solution at 15° C. This treatment will soon be discussed at a Paris medical society.—*Br. Med. Jour.*, Nov. 23, 1889.

Cant (W. E.) on Keratitis from Paralysis of Fifth Nerve.—A lad, aged sixteen, was seen on July 17, 1888, with complete paralysis of the left fifth nerve. The left eye showed some general injection, and the cornea was diffusely hazy. A history was obtained of an injury by a reaping-hook two or three weeks previously, and a doctor who saw the lad two days after the blow had been inflicted, found him in a semi-conscious state. There was a small penetrating wound of the squamous portion of the left temporal bone, about an inch above the insertion of the auricle; into this wound a probe could be passed to a depth of rather more than one inch. When seen again on July 22d, the left cornea was quite opaque, of a milky-white color; there was much general congestion of the eye. He was admitted to the hospital. During the next three weeks the condition of the left cornea became rather worse, and marginal ulceration occurred. The paralysis of the fifth nerve remained complete. The patient then left the hospital, and was not seen again for four months. When he returned the left cornea had partially recovered, but was still generally hazy. The function of the fifth nerve, both muscular and sensory branches, had been regained, but to only a limited degree. Mr. Cant thought the case had been one of direct injury to the whole fifth nerve within the skull, between the brain and the Gasserian ganglion, or at the latter.—*Br. Med. Jour.*, Oct. 26, 1889.

Farlow on Concretion from the Tonsil.—The body, originally the size of the head of a large shawl-pin, the author had removed from the tonsil of a girl of eight years. She had been troubled for

some time with a hard paroxysmal cough, worse at night, and bad breath. She had been seen by several physicians, who had simply considered the tonsil enlarged, and had prescribed cough syrups in vain. By hooking forward the anterior pillar of the fauces, in a depression between the large lower lobe of the tonsil and a smaller upper lobe, could be see this large concretion, which was removed by the dull curette. The cough was cured, and the breath was no longer offensive.

Dr. Farlow thinks that these depressions, which are often concealed by the anterior pillar of the fauces, and which are frequently the seat of these large concretions, are generally overlooked in examining the throat.

In the discussion following the presentation of this specimen, Dr. F. I. Knight said:

"I once saw a case of exactly the same kind, only the concretion had become very hard and calcareous. It was in a lady, between forty and fifty years old, who had had paroxysmal cough and pain in the side of the throat for many months. I saw her three or four times before I discovered this thing. On probing into the crypts of the tonsils, I struck something hard, and on enlarging the opening and putting in a bent probe I hooked out this mass, which was as large as a pea, and the removal of which gave instant relief to the cough."—*Boston Med. and Surg. Jour.*, Nov. 14, 1889.

Cagney (J.) on the Faradic Brush in Locomotor Ataxy.—A man of fifty came under observation late in 1886. He was in an advanced stage of tabes, in the highest degree ataxic; gait so exaggerated that he could not walk a mile without great fatigue; the tendon reactions altogether gone; Argyll-Robertson pupil, marked color-blindness, and restriction of the field of vision; visceral and peripheral pains intense and almost unremitting. I applied a strong current to the trunk and lower limbs with the faradic brush several times a week. The pains gradually left; the sleep, which they disturbed, was restored, and general nutrition greatly improved. At the same time co-ordination and tactile perception slowly mended, while the visual symptoms remained. At the end of two months the patient went, by my advice, to a convalescent home, and came back in a fortnight to say that he considered himself well. He had walked nine miles without fatigue, and was entirely free from pains. He came back from time to time to assure me that this state of things continued, and then left altogether. At that time he could not stand long with his eyes closed, but walked with ease, and his upper limbs were quite restored. I met him two years afterwards, when he brought his wife to the hospital to be operated upon, and he was then slowly relapsing to his former state.

After this I treated several cases in a similar manner, entirely relieving pain in the majority, and securing at the same time in two instances a general amendment of the patient's condition. My experience has convinced me that there is in this a useful resource which should not be neglected, though it has no pretensions to be thought a radical cure. Neither would I concede such to the suspension treatment. The prospect of a cure for so formidable a disease as locomotor ataxy has naturally given rise to great hopes, and great hopes make room for no less disappointment. Neither seem quite justified here. The method is empirical, and it should be tested by patient observation. The disease has in it much that is obscure, and it may be safer to treat it rather as a collection of symptoms than as a clinical entity. It may then be found that the relief of certain of these—a great result in itself—will influence the progress of the others, and a step towards the truth will be made. —*Br. Med. Jour.*, Nov. 16, 1889.

Tilley (R.) on the Product Obtained from Milk after the Separation of the Cream by Centrifugal Force.—There is found adherent to the inner wall of the centrifugal separator, after considerable milk has gone through the process, a thin, solid layer composed largely of materials foreign to pure milk. This the author surmised might contain interesting material, so he collected some of it and, with Dr. Frank Johnson, examined it microscopically. They found it to contain abundant red blood corpuscles, leucocytes, granular epithelium, connective-tissue fibres, dirt of all sorts, textile fibres, large rod-shaped bacteria, and numerous tubercle bacilli. The author queries whether the skim milk from these creameries might not, under the circumstances, be safer to drink, although he does not assume that all the dangerous ingredients are eliminated by the separator.—*Western Med. Reporter*, Nov., 1889.

THE MEDICAL ANALECTIC

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SOME RECENT CONTRIBUTIONS TO RENAL SURGERY.

BY GERTRUDE B. KELLY, M.D.

Danforth (I. N.) on the Evolution of the Cystic Kidney.—By cystic kidney is meant that condition of the organ in which it is more or less completely converted into a number of cavities, containing fluid or semi-fluid matter, and possibly solid matter as well. The number of these cavities varies greatly, sometimes being limited to half a dozen, or even less, sometimes reaching several hundred. The size of a cystic kidney varies greatly. Sometimes it is not perceptibly enlarged; at other times it is enlarged to three or four times its normal dimensions. The causes of cystic or sacculated kidney may be classified as follows: 1. Diathetic causes: (*a*) excess of saline constituents in the urine, (*b*) tuberculosis, (*c*) carcinoma. 2. Congenital causes: (*a*) floating kidney with consequent "twist" of the ureter, (*b*) congenital hydronephrosis, (*c*) congenital degeneration of elements. 3. Mechanical obstruction, dependent upon disease of the pelvic organs. 4. Traumatic causes. 5. Pathological cysts: dermoid cysts, hydatids, cystic metamorphosis.—*Med. and Surg. Reporter*, May 26, 1888.

Landau (L.) on Intermittent Hydronephrosis.—At the meeting of the Berlin Medical Society, held on Oct. 19, 1888, Dr. Landau said that the case brought forward by him in 1880, in which the hydronephrosis turned to a pyonephrosis, and left behind it a renal fistula, was the ninth recorded case of the kind. He had since then observed four other such cases. By intermittent hydronephrosis he understood that accumulation of urine in the pelvis of the kidney from some undefined cause, relieved by sudden emptying, and subsequently recurring. In his cases the hindrance to the proper outflow of urine was only imaginary. The most remarkable kind is that accepted in literature as bilateral spasm of the ureters, that causes anuria. He said that he had observed spasm of a similar kind in the dead body, in attempting to pass hot water through the ureters. The ureter contracted so firmly that not a drop of urine could be induced to pass. There were, however, two other kinds of occlusion, one from direct dragging and pressure of the ureter against the pelvic arch, and the other from acute flexion of the ureter, or from its insertion at an acute angle. As regards the first kind, Virchow showed in 1846 that a prolapsed and irreducible uterus had so pressed the ureter against the pelvic arch that the ureter and the pelvis of the kidney were distended with urine. The patient died of uræmia. Another case of double hydronephrosis showed that it must have been intermittent, as the patient could not have lived as long as she did. He had not yet succeeded in demonstrating this ob-

struction during life. The second form of obstruction was frequent enough, as Cohnheim had shown. The stasis of urine persisted as long as its cause, and then the collected fluid flowed off. This was repeated so often that the elasticity of the pelvis of the kidney began to suffer, and it finally attained such a size that the tumor had even been mistaken for one of the ovary. The question arises as to how acute-angled insertion takes place. Virchow considers that it is congenital. Simon held it to be a necessary consequence of hydronephrosis. The acute-angled insertion could not be congenital in the majority of cases; but it was remarkable that the affection was most frequent on the right side, and this is in favor of the assumption that the acute-angled insertion is acquired, produced by a movable kidney. The kidney sinks, and the hydronephrosis is caused by acute flexion of the ureter.

The symptoms in his five cases were fairly constant. They all complained of occasional uneasiness, and of the feeling of a foreign body, but nothing as to the urinary function. One patient complained of attacks resembling renal colic. The objective symptoms were not striking at the beginning. Fluctuation could not be detected in his cases. The tumors were remarkably hard. Puncture was not always reliable, as the contents of the hydronephrotic sac did not always contain urinary constituents. As regarded treatment he was opposed to nephrectomy, as one could entertain the hope that after emptying the sac further flexion of the ureter might be prevented by support and rest. The disease, however, might become pyonephrosis, and if the other side became involved, the patient would be lost. When the symptoms were grave, fear of operation should not deter one from acting. A fistulous opening might be made. One of his patients had such a fistula for eight years, and was otherwise quite well. Hahn's proposal was to stitch the sac as high as possible in the abdomen. In some cases, by assuming a favorable position, or by kneading, the sac may be caused to empty into the bladder.—*Med. Press*, Nov. 21, 1888.

Griffiths on Histological Change in Hydronephrosis.—Two distinct processes occur in such kidneys. The first, present in all examples, is the result of the accumulated urine in the distended pelvis, and is limited to a thin layer of tissue, immediately subjacent to the surface pressed upon. The changes observed are increased proliferation of the intertubular connective tissue, disappearance of some of the renal tubules, and dilatation of the remaining ones. The second, present usually in those examples in which distension of the body of the pelvis had occurred, he considered similar to chronic interstitial nephritis from other causes. He referred this general interstitial process specially to the compression of the renal vessels in their course over the distended body of the pelvis; and he told of a case of unilateral interstitial nephritis, produced by compression of the corresponding renal artery by an aneurism of the aorta, in support of his view.—*Lancet*, Feb. 9, 1889.

Bozeman on Colpo-Uretero-Cystotomy.—1. An artificial fistula at one of the ureteral angles of the trigone of the bladder, the result of the operation of colpo-uretero-cystotomy, furnishes an opportunity for the observation and clinical study of disease of the bladder, the ureters, the pelves, and the kidneys, afforded by no other means. Specimens of urine have been obtained from the ureters by catheterization through the urethra, but the information to be obtained by this means is necessarily limited, and the procedure is open to various objections. The practice of forcibly dilating the urethra in order to facilitate the catheterization is unjustifiable, because it frequently results in incontinence of urine. Catheterization without dilatation of the urethra—"free handed," as it has been called—is a very difficult operation. I have made repeated attempts within the last few years to perform this surgical feat, but they were all failures. This method also involves an amount of probing which is injurious to the bladder, especially if cystitis is already present. In order to be certain of the source of the pus, especially if it be present only in moderate quantity, the catheter must be passed along the whole length of the ureter to or into the pelvis of the kidney, as the pus may come from the ureter, for ureteritis at the vesical portion of the duct is a very frequent complication of cystitis. In consequence of the spiral course of the ureter, only a very flexible instrument can be passed with safety into the pelvis of the kidney, and in order to discover the ureteral orifice by probing the bladder, a

moderately stiff catheter must be employed. When an opening into the bladder has been made, the orifice of the ureter can be exposed to view, and the most flexible instrument guided into it.

2. The means of easy access to the bladder, the ureter, and the pelvis of the kidney afforded by the operation of colpo-uretero-cystotomy are even more important for treatment than for diagnosis. Irrigation of the pelvis of the kidney removes pus and ammoniacal urine from contact with its mucous membrane. Gradual dilatation of the ureter overcomes narrowing of the duct at its orifice or along its course; the escape of irritant substance from the pelvis is then made more easy, and the descent of a calculus impacted in the ureter would be facilitated. Physiological rest and perfect drainage of the bladder, the ureters, and the pelvis tend to cause the subsidence of inflammation of their lining membranes, and atrophy of their thickened muscular coats. In consequence of the removal of the pressure of the urine, an enlarged bladder or a dilated pelvis returns to its normal size.

3. By this new method of treatment, the patient is exposed to but little danger in comparison to that involved in the grave operation of nephrotomy and nephrectomy. These major operations are seldom done, except at a later period, when extensive renal disease has occurred, and, if the case does not terminate fatally, result in the complete loss of one of two vital organs. The complicating cystitis is not treated by them, and causes which may afterwards lead to disease of the remaining kidney are neglected. Congenital absence of one kidney, coincident disease of both, and pyelitis on both sides, are contra-indications to the performance of the operation of nephrectomy, but not to the employment of this new method of treatment. Colpo-uretero-cystotomy should be done early. By the operation and the subsequent treatment, the associated lesions of the bladder will be cured, and in many cases all the urinary organs restored to a normal condition. In many other cases, by the accurate means of diagnosis afforded by the opening in the bladder, allowing the use of the catheter and the renal sound, a stone in the pelvis of the kidney too large to pass through the ureter, extensive suppuration of the kidney itself, or some other condition not susceptible of cure by this method of treatment may be discovered. Nephrotomy or nephrectomy may then be resorted to with greater confidence and an increased probability of success. The patient is meanwhile relieved from the distress resulting from the complicating cystitis and pyelitis. The vesical and pelvic irritability and tenesmus no longer causing loss of sleep, her general condition can be improved, and she is better prepared to undergo a serious operation.

4. Intravaginal drainage prevents the evil consequence of incontinence of urine, and perfects the method by removing the chief objection to its employment.—*Amer. Jour. of Med. Sci.*, April, 1888.

THERAPEUTICS.

Ether, Chloroform, Nitrous-Oxide Gas and Ether.—An anonymous physician thus writes to the *Lancet*, Dec. 7, 1889: "On six different occasions within the past ten years I have unfortunately required the administration of one or other of the above mentioned anæsthetics. My initial experience was with ether, which was given me in a towel formed into a cone with a sponge at the top. After getting over the choking in the first, and on passing into the second, stage, I became so violently delirious that it required the utmost efforts of three strong men to restrain me. I may say that I am a powerful man, and was at the time in training for boxing. The after-effects —sickness, nausea, and general misery—I did not get over for quite forty-eight hours. My next experience was with chloroform, which I have had in all four times. It was administered on each occasion through a Junker's inhaler. I quickly went under, and as quickly came to; but the nausea, which lasted from thirty-six to forty-eight hours, was very trying, and exhausted me a good deal. Quite recently I have had to seek the services of a surgeon at another hospital; and when informed in the theatre that it was intended to give me ether, I must say that I dreaded the anæsthetic much more than the surgeon's knife. I was first given nitrous-oxide gas to produce insensibility, and then ether was substituted. Altogether I was twenty minutes inhaling the latter. Within a few minutes of removing the ether I was able to answer questions, although I did not not fully recover con-

sciousness until removed to my ward, and within an hour I was entirely free from all unpleasant effects of the anæsthetic, and able to partake freely of bread and milk. I may add that on each occasion I was prepared *secundum artem* for the reception of the drug, and the time of inhaling lasted about the same—viz., twenty minutes."

Purdy on a Case of Poisoning by Chloral.—A drunkard on the verge of delirium tremens was given a mixture containing 180 grains each of chloral and pot. bromide, one eighth to be taken for a dose. The whole was taken at once, and the patient, seen shortly afterwards (at 4:15 P.M.), was in a comatose condition, with stertorous breathing; the pulse could not be counted, and the complexion was livid; the pupils were contracted. The stomach was washed out and coffee injected. At 6:10 the patient could be slightly roused and the pupils were dilating. Cutaneous irritation, forced exercise, and cold affusion to the head were used and liq. strychniæ ♏ 4 and liq. atropiæ ♏ 3 injected. He gradually gained strength, and in ten days' time was enabled to resume his usual occupation. Some weeks later he died rather suddenly, and the necropsy showed cirrhosis of the liver, enlargement of spleen and kidneys, and a heart with firmly adherent pericardium. Dr. Purdy called attention to the large dose from which the patient, though constitutionally diseased, recovered, and thought that, of the measures adopted for treatment, the most effective was cold affusion to the head.—*Br. Med. Jour.*, Nov. 9, 1889.

Salol in Gonorrhœa.—Dr. Dreyfous has treated seven cases of gonorrhœa with salol. The doses varied from 5, 7, to 8 grammes. The discharge was less abundant. In a recent case, in which gonorrhœa appeared some time before seeking advice, Dr. Dreyfous obtained a complete cure in a few days. M. Dreyfous has tested the effect of salol administered alone, and in other instances he has given it simultaneously with copaiba and cubebs in order to hasten the cure. He recommends the use of salol to surgeons who operate on the urinary organs; it renders urine aseptic, which is thus innocuous when in contact with raw surfaces. Aseptic and antiseptic conditions result from giving salol internally.—*Br. Med. Jour.*, Dec. 7, 1889.

Wilson (J. C.) on the Treatment of Scarlet-Fever by Chloral Hydrate.—The author's plan is as follows: First, a laxative dose of calomel proportionate to the age and general condition is administered. Shortly after, chloral is given in moderate doses, at intervals of two or three hours, or longer, throughout the attack. Profound narcotism is, of course, to be avoided. Nourishment is generally given immediately after the medicine.

The author thinks that part of its beneficial action is due to the antiseptic effect of the drug upon the throat and kidneys. If, late in the disease, the heart flags, alcohol is given. The customary cleansing disinfectant care is taken of the throat, and from the time of the eruption, inunction of freshly washed lard is practised. During convalescence quinine, nux vomica, and iron are indicated.—*Med. News*, Dec. 14, 1889.

Schultz (W. M.) on the Use of Acetanilide in Reflex Cough.—Mrs. T., a multipara, had from the fourth month, in two pregnancies, a most distressing and incessant cough, ceasing only with the birth of the child, and then instantly, with no return. In a recent pregnancy with a similar cough, I put her on small doses of acetanilide, and in forty-eight hours she was comfortable, and, after a week, a 3-gr. powder a day was sufficient to completely control the cough, and now, after six weeks' use of the powders, is scarcely troubled in the least. About the only thing she notices is a slight disposition to clear the throat, which, upon inspection, appears normal.—*Therap. Gaz.*, Nov., 1889.

Curgenven (J. B.) on Eucalyptus in Cancer.—I lately had a case of cancer of the breast in which the ulcerating surface was about eight inches by six. The odor from the discharge was most sickening and offensive, and it was made worse by the odor of the carbolic acid which they were using. No one could remain in the room long with the patient on account of the intolerable smell. The carbolic acid was stopped, and the eucalyptus disinfectant used. The wound was sprayed with it, as also the lint with which it was dressed; tenax was wetted with it and placed under the wound to catch the discharge, and, by the use of a spray diffuser, the air of the room was filled with the fragrant odor of the eucalyptus. All offensive smell at once ceased, and there was only the smell of an ordinary suppurating surface.

In a case of cancer of the sigmoid flexure where the discharge was frequent and very offensive, the injection of a small quantity of eucalyptus emulsion twice a day stopped the offensive odor, and checked the frequency of the discharges. And in a case of cancer of the neck of the uterus, the offensive smell was stopped, the discharge lessened in quantity, and the tendency to hemorrhage diminished.—*Br. Med. Jour.*, Dec. 7, 1889.

Squire (B.) on a Case of Diabetes Improved by Phosphorus.—A man of sixty, with diabetes of long standing, was also annoyed by an eczema of the face, neck, and upper extremities. For the latter condition particularly phosphorus was ordered. The first three days he took $\frac{1}{10}$ gr. a day, the next seven days he took $\frac{1}{8}$ gr. a day. The effect of the drug was very beneficial to the eruption, and to many of the diabetic symptoms also. He ceased to arise at night to pass water, the amount of which suddenly diminished very much; the thirst ceased, and his general health was much improved. The sugar, although in lessened amount, was still excreted.

That the administration of phosphorus acts most decidedly on the liver is well known, because, in undue and over-prolonged doses, phosphorus is capable of producing fatty degeneration of the liver. This circumstance would seem to afford the clue to its marked action in this case in controlling diabetes. It is possible that the effect of the phosphorus may be due to its action on the nervous system.—*Br. Med. Jour.*, Nov. 30, 1889.

Maynard (F. P.) on Antipyrin in a Case of Suspected Snake Bite.—At 8:30 A. M., on July 11th, a small dog was smelling about in the rather long grass near some trees, when she was seen to jump and then run. Marks of a tooth-bite were found on the left side of the tongue. There was no salivation. The dog very soon seemed ill and restless, and presently slight convulsions came on, which grew more severe, and they sent off for me to the hospital, some distance away. I saw the dog about 9:30. She was then lying on her right side, unconscious, with dilated pupils, head drawn back, back arched, and all four legs sticking straight out rigidly. Clonic spasms, very rapidly succeeding each other, shook her all over; mouth dry; respiration very rapid. On the left edge of the tongue were two distinct marks of teeth, one above and one below. There was no swelling at all near them. She was not passing water or fæces. I thought the dog had been bitten by some kind of snake and was dying, and hardly knew what to do; so I gave her some whiskey. Then, feeling her very hot, I took her temperature, and found it to be 106.2° F., and having some antipyrin by me in gr. x. powders, I gave her gr. x. dissolved in strong whiskey and water at 9:45. At 10:15 her temperature was 104.2°, but the spasms remained the same, though her pupils were contracting. The dose was repeated with more whiskey. At 10:40 the temperature was 101.8°, the convulsions were lessening, and the dog recognized me. She previously, I should say, had tried to get on her legs, and had performed "circus movements." Five grains more were given, and at 11 A. M. the temperature was normal, the convulsions had ceased, and the dog, beyond being stiff and weak in her hind-legs, was apparently well. She slept the greater part of the day, refusing to touch any thing, and has been as well as ever since. Altogether she had gr. xxv. of antipyrin and ℥iss of whiskey.—*Practitioner*, Dec., 1889.

Goldenberg (H.) on an Exanthema after the Use of Rhubarb.—A sailor, of sixty-four, with rheumatic symptoms, was put upon a solution of the salicylate of sodium. To remedy a constipation he took, on his own responsibility, rhubarb and Hamburg tea. After this latter medication an eruption appeared on each malar prominence. This eruption consisted of from fifteen to twenty brownish-red, irregularly shaped pustules, deeply infiltrated at their bases, and surmounted by a superficial pustular formation, the whole being surrounded by an inflammatory area. Some of the pustules were large, and had cribriform openings covered by a thick crust. A similar lesion was present on the dorsum of each hand. The lesions gradually went away in a few weeks, leaving a bluish discoloration, but no cicatrices. A similar condition was produced by a subsequent administration of rhubarb.—*N. Y. Med. Jour.*, Dec. 14, 1889.

Crossland (J. C.) on a Case of Poisoning by Coal Gas.—The symptoms in the case were stertorous, shallow respiration, with abundant mucous râles; barely perceptible radial pulse; eyes partly open, fixed, and insensible to touch; pupils

moderately dilated, and not responding to light; conjunctivæ congested. Face and extremities were livid, patient cold and moribund. Various stimulants, external and internal, were employed, but the subcutaneous use of nitro-glycerine[1] seemed the most efficacious, and to it the writer attributes the successful outcome of the case.

Fifteen to twenty minims of a 1 % solution were given at intervals of from thirty minutes to two hours.—*N. Y. Med. Jour.*, Dec. 14, 1889.

Ammonia in Cocaine Poisoning.—A case of poisoning by a very moderate quantity of cocaine is reported by Dr. Golovkoff, in the Proceedings of the Caucasian Medical Society, where ammonia was used with good effect to restore the patient. The patient was a somewhat delicate woman, who was suffering severely from toothache. The pain becoming unbearable, Dr. Golovkoff injected fifteen minims of a two-percent. solution of hydrochlorate of cocaine under the skin of the left cheek, which gave relief for three or four hours, when the pain returned as acutely as ever. A second fifteen minims were injected, and in about five minutes' time the patient became restless, her pupils dilated, the surface of the skin became pale, the pulse and likewise the respiration became rapid, and shivering came on. A curious effect, too, was produced on the sounds of the heart, causing them to be audible at the distance of two paces from the patient. There was great pain over the cardiac region and back, together with a dread of death and convulsive movements of the limbs. There was some liquor ammoniæ at hand, and this the patient was given to smell, and a few drops were given internally every five or ten minutes. Amyl nitrite was also employed, but the latter seemed to do more harm than good, while the ammonia soon brought the pulse and respiration, and indeed the general condition of the patient, into something more like their natural condition, so that in about a couple of hours she had quite recovered.—*Lancet*, Nov. 30, 1889.

Raven (T. F.) on Chronic Eczema Treated with Oleum Deelinæ.—A boy of three began to suffer from eczema; it originated, without doubt, from injudicious feeding. The face was first affected, and subsequently the whole surface of the body. At different times the limbs, back, face, and neck would be most severely attacked. The disease proved intractable for a number of years, during which time he was twice in hospital, under the care of one of the most eminent dermatologists, and although much good was gained at the time, the improvement was not maintained for more than a few weeks.

In February of this year I commenced the use of oleum deelinæ. It was first applied to the left forearm, and in forty-eight hours the result was so good that I had it painted over the whole affected surface—nearly half of the body—night and morning. In six weeks the disease was practically cured, after thirteen years' duration, and although the patient has some occasional reminders of the old enemy, and the skin is still harsh and thickened, yet he is now, after eight months, capable of doing a fair share of daily work as an artisan, while his general health, which had considerably suffered, is proportionately improved.—*Lancet*, Nov. 30, 1889.

Braithwaite on Chloride of Zinc as a Caustic in Cancer of Female Generative Organs.—The author thus summarizes the advantages derivable from the use of chloride of zinc as a caustic in cancer of the female generative organs. 1. When the knife could be used it was usually preferable to employ it, and only resort to the zinc upon the first appearance of a return. 2. In some cases the zinc should be the first, and indeed only weapon used, as in commencing cancer of the cervical canal of the uterus, when, from any cause, the organ could not be pulled down into view, as when the uterus was fixed by old inflammatory adhesions. In commencing cancer of the vulva or vagina, if the disease were superficial and not of great extent, this treatment alone was necessary, but it might or might not be preceded by erosion a few days before. 3. It should be applied by means of a very thin layer of cotton-wool wetted with the zinc solution and lightly pressed between two pieces of blotting-paper. It then did not run. 4. A saturated solution should be used. The fluid resulting from the deliquescence of the solid was the most convenient form. 5. The caustic required time. Usually, in twenty-four hours it had acted sufficiently; but, if a deeper action were required, it might be left longer. 6. Its use was followed by great contraction of the parts—a safeguard to some extent against return of

[1] See MEDICAL ANALECTIC, 1889, p. 225.

the disease. In this, as in other respects, it was superior to Paquelin's cautery, acid nitrate of mercury, and potassa fusa. One case was related in which a slough was made of the whole interior of the uterus, not too deep to be dangerous, but sufficient to remove the surface and some of the adjacent tissue. The patient was being weakened by hemorrhage and poisoned by absorption of the sanious discharge.—*Br. Med. Jour.*, Nov. 16, 1889

MEDICINE AND PATHOLOGY.

Tubercular Inoculation.—I. Gescheit (*Internationale Klinisch. Rundschau*, 1889, No. 23) reports five cases occurring in children within a period of ten months, where from three to four weeks following ritualistic circumcision ulcer of the penis, with inguinal-gland enlargement, appeared. At the beginning they were treated as syphilitic. Three of the children died at the age of four months from meningitis and enteritis. The circumciser, who was affected with tuberculosis, had sucked the surfaces of the wounds. Their tubercular nature was afterwards recognized. Dr. Paul Gerber (*Deutsche medicinish. Wochenschrift*, 1889, No. 16), giving a short account of the literature of the subject, reports his own experience. In Nov., 1887, making an autopsy on a phthisical patient, he cut his little finger while cutting the lungs. The same night he experienced pain in the hand with swelling and redness, extending above the hand, and slight constitutional disturbance. The symptoms disappeared after twenty-four hours, but the wound did not heal. After four months the diseased tissue was excised with the scissors, when the glands of the axilla of the affected side became painful and swollen, and in a few days fever was added, which continued for seven weeks, the patient passing into a condition resembling typhoid, the fever being diagnosed as this disease. During this time the wound of the finger healed and the glands remained swollen but not painful. When the fever disappeared the glands began again to be painful. On the 5th of June the glands were excised and examination of them revealed giant cells and a few tubercle bacilli. There was no return of symptoms of tuberculosis in any other part of the body in December, 1888. The patient came from a healthy family with no hereditary tubercular predisposition. W. V.

Stern (R.) on the Effect of Ventilation on the Micro-organisms Suspended in the Air.—From experiments conducted in the hygienic institute at Breslau, the author found that when the air of a room was undisturbed the particles of dust containing micro-organisms were deposited on the floor of the room, and that after 1–2 hours the air was almost free of germs. If the floor was then washed with an antiseptic solution and the furniture wiped with a dampened cloth that the room could be considered as disinfected. That ventilation sufficient to change the air contained in the room, four times an hour, had but slight influence on the removal of the germs floating in the air, but that a draught of air sufficient to change the quantity seven times an hour, accomplished this quickly and completely. That stronger draughts did not dislodge germs from the floor, carpets, furniture, or clothing, and that the airing of infected clothing, bedding, carpets, etc., was useless unless accompanied by beating and brushing of the same, which in its turn, in the case of pathogenic organisms, would be hazardous. *Zeitschrift für Hygiene*, 1889, Bd. vii., abstracted in *Centralblatt für Chirurg.*, 1889, No. 47. W. V.

Bell (J.) on a Case of Loss of Memory Following Cranial Injury.—The following case is reported by the patient, a distinguished member of the legal profession. The loss of memory has been permanent for certain subjects extending over a certain area of time preceding the accident. In all other respects the mental faculties are of a very high order.

"When twelve years and ten months old I fell over a cliff at Howth, County Dublin. The cause of my accident was a kind of landslip, and I fell and rolled about thirty feet when I caught a bush, which gave way with me, and I fell about thirty feet more on to rocks. I was picked up quite insensible. My jaw was broken in four places, but no other bones. I am told, however, that my appearance was like that of some one who had been beaten into a jelly from head to foot. I have no recollection of the accident beyond holding on to the bush or bramble which gave way with me. Nor do I remember being picked up, nor any thing which subsequently oc-

curred, until about ten days after the accident, when I seemed to awake out of a long sleep, in great pain, and seeing Surgeon Butcher standing over me and setting my jaw, or doing something to it which caused me great pain.

"I was more or less incapable of doing any thing for seven or eight months owing to the shock to my system. My father had died about seven months before the accident, and I am told that I used constantly to be with him, and that he was very fond of me, but I have not the smallest recollection of him, or what he was like, nor can I remember a single incident of my life before the accident, and, in fact, up to the time it occurred every thing is a complete blank in my memory both as regards individuals and events.

"I am told that I was practically insensible for about a week after the accident occurred."—*Edinburgh Med. Jour.*, Dec., 1889.

Greene (G. E. J.) on Morbid Stethoscopic Sounds not Produced by Disease in Patient.—Both pupil and teacher frequently spend long periods in practically studying crepitation, etc., and seldom take into consideration that an artistic haired student occasionally generates those sounds in the vicinity of his own ear, whilst a "*hairy* patient" not having any thing wrong with his lungs produces morbid sounds much better.

Pleuritic friction sounds are well simulated by the patient rhythmically applying his finger ends to his abdominal or other cuticle, while his physician is engaged in auscultation. Now taking into consideration the numerous causes of, and necessities for, scratching among the lower sections of society, and the variability of timbre, rhythm, and intensity produced according to the locality undergoing massage, the vigor, regularity, or irregularity of its application, etc., it need not be wondered at when I say that itchiness (prurigo) may be classed as one of the most frequent causes of phantom morbid stethoscopic sounds. Other sources of error which have from time to time come under my notice are various articles worn by patients coming in contact with stethoscope, the friction of articles of clothing against each other, sounds produced by bed when knelt upon, sounds caused by constrained position ot the doctor's clothing, etc., in awkward positions whilst examining patients too feeble to be moved, noises arising in the room or next door (sewing machines, etc., etc.), the imperceptible slipping of the stethoscope, and last, though by no means least important, bruits in auscultator's ears, the result of catarrh or organic disease.—*Med. Press*, Nov. 27, 1889.

Ely (J. S.) on Tuberculosis of an Artery Illustrating One of the Modes of Dissemination of Tubercle Bacilli in the Body.—After a very full resumé of the literature of the subject, the author presented, at the recent meeting of the N. Y. Pathological Society, a section of the upper lobe of the left lung of a child who died of acute miliary tuberculosis. Autopsy revealed very large and cheesy bronchial glands, and scattered through both lungs were many miliary and submiliary tubercles. At the apices and in the vicinity of the bronchial glands cheesy masses of conglomerate tubercle were found. But what was of especial interest was the encroachment of many of the tubercles upon the walls of blood-vessels. In places the walls of veins were affected, in others those of arteries. The most beautful of these was a small artery near the base of the upper lobe, which was encroached upon by the miliary tubercle immediately adjoining it, and in which a tubercular arteritis was seen. The wall of this vessel was infiltrated with small round cells, and, projecting into its lumen, and partially occluding it, was a mass of small round cells, in the centre of which cheesy matter was distinctly visible. It will readily be appreciated how slight a variation in arterial pressure might be sufficient to cause this degenerating mass to be thrown into the circulation, and carried by it to any part of the body. Tubercle bacilli were found in these lesions in other sections from the same lung.

A specimen of tubercles in a vein was presented by Dr. Northrup, at the same meeting.—*Med. Record*, Dec. 14, 1889.

Chrobak (R.) on Induration and Ulceration of the Cervix.—The condition had come on during pregnancy, and the appearances were such as to suggest carcinoma, as there was no evidence of syphilis. Premature delivery was effected four weeks before term, and immediately afterwards all the diseased parts were excised. Recovery took place without reaction. Two years and a half later—the patient in the meanwhile having enjoyed perfect health—an induration, similar to

the first one, of the rest of the cervix supervened, again during pregnancy. Miscarriage occurred spontaneously at ten weeks; after which the disease disappeared. In microscopical sections a very copious, small, cellular infiltration, with emigration of cells through the walls of the blood vessels, was visible. The cells were also grouped around the blood-vessels. As an organized neoplasm and tuberculosis could be with certainty excluded, it remained doubtful whether there was an abundant escape of cells during the fluxion produced by pregnancy, or whether, after all, the disease was of syphilitic origin.—*Br. Med. Jour.*, Nov. 23, 1889.

Maydl on Actinomycosis of the Tongue.—The patient was himself a physician, acting as a veterinary inspector at a Polish town, where he had to watch over the importation of cattle from Russia. As he had to look sometimes through hundreds of papers containing particulars of the consignments of cattle, he became accustomed to moisten his fingers on his tongue, in order the more easily to turn over the numerous sheets of paper presented to him by the cattle drivers. After indulging in this habit for some months he observed a swelling of his tongue, which he feared at first to be a cancer; but taking also into consideration the fact that several cases of actinomycosis had been observed among the cattle examined by him, he believed in the possibility of an infection by the disease. The microscopical examination of the pus discharged revealed the presence of actinomycosis. The actinomycotic abscess was scraped out, and the patient recovered soon after the operation.—*Lancet*, Nov. 30, 1889.

Sheard (C.) on the Prognostic Significance of Moderate Cardiac Hypertrophy and Dilatation.—The author concludes:

1. A diseased valve may be restored to funcional activity and leave no ill effects.

2. The diseases of the heart most liable to cause sudden death are aortic regurgitation and fatty disease.

3. That in aortic stenosis the patient has generally the longest lease of life given with any valvular disease, and may live for years after moderate hypertrophy exists.

4. That aortic obstruction and aortic regurgitation when associated constitute the most grave of all cardiac lesions.

5. That lesions of the mitral valve, both obstructive and regurgitant, are slow in causing death.

6. That simple irregularities in the heart's beat may be classed with functional disorders as not showing liability to organic disease.—*Canadian Pract.*, Dec. 2, 1889.

Murphy (P. L.) on a Pervious Urachus.—Last June, while out with a party surveying some land the Asylum had bargained for, I noticed a negro boy helping the surgeons, who had a peculiar rocking walk, with curvatures of the bones of the thighs and legs, a large misshapen head, and other indications of rickets and scrofula. Just as I was leaving he stopped and asked me to examine him. His shirt and pants were wet from the navel down to the knees, and gave out a strong ammoniacal odor. Several days afterwards he called at my office, when I gave him a more careful examination. There was a fissure running from the navel to the pubes, which I at first thought might be an epispadias, but, pulling the sides of the fissure apart, I saw that it was simply a fissure three-quarters of an inch deep, the bottom and sides being moist. There were also smaller fissures running in different directions, varying from one to three inches in length, giving the abdomen in this region a wrinkled appearance. There was no other sign of a navel. By examining with a lens, I found the orifice of the *urachus*, which I soon was able to make out with the naked eye. In size it was not longer than a pin's head. A whale-bone bougie passed through it into the bladder without difficulty. At times, the boy said, the dribbling through this passage was small; at others most of the urine apparently passed this way.—*North Carolina Med. Jour.*, Nov., 1889.

White (H.) on Rupture of Chordæ Tendineæ of Mitral Valve.—The patient, a man aged nineteen, who had had rheumatic fever some years previously, was one day following his ordinary occupation when he was so suddenly taken with shortness of breath that he had to go home to bed. This dyspnœa increased until his admission to the hospital. He was then found to have an aortic to-and-fro murmur and a loud mitral systolic thrill, and the heart was considerably dilated. Digitalis always reduced the frequency of the pulse by a few beats for a quarter of an hour after administration, but it soon became as rapid as before the drug was given. The points of interest about the case were that the chordæ ten-

dineæ ruptured suddenly in a man who was able to do his work, that there was a systolic thrill, and that digitalis was almost powerless.—Dr. Dickinson quoted the case of a bricklayer, aged twenty-four, who, being apparently quite well, and while engaged in lifting bricks, became suddenly collapsed, and was found on examination to have an extremely well-marked mitral murmur. The lesion was diagnosed as rupture of the chordæ tendineæ of both mitral valve cusps, and this opinion was confirmed at the necropsy.—*Lancet*, Dec. 7, 1889.

SURGERY.

Bellamy (W. J. H.) on Perityphlitic Abscess, Lacking the Usual Symptoms; Cure Effected by Drainage through the Perineum.—A strong man of sixty-two was seized with a chill and fever July 14, 1889. For eighteen days the symptoms were only those of quotidian fever, and were treated accordingly. On the eighteenth day some dysuria and a sense of discomfort in the perineum, where some tumefaction existed. The next day a swelling appeared above the pubes, inclining to spread to the right side. This was opened and more than a pint of foul-smelling, dark-colored pus was evacuated. A large piece of necrotic omentum presented itself at the wound, was ligated and removed. Continuity of this pus-cavity with the swelling in the perineum was made out, and to secure through drainage an incision was made in the perineal swelling, and at the depth of one and a half inches pus was reached and a communication established with the suprapubic opening. A drainage tube was passed through and antiseptic dressings applied. More omentum was removed from time to time; but in a fortnight or so the drainage tube, having slipped out, was not replaced, and perfect recovery supervened.—*North Carolina Med. Jour.*, Oct., 1889.

Godwin (C. H. Y.) on the Treatment of Varicose Veins by Injection of Carbolic Acid.—For some years past the author has treated varicose veins of the leg by the following method: The skin over the varix should be washed with a 1 in 20 carbolic solution, and the part covered up with lint wet with the solution for some hours before the operation. At the time of operation a hypodermic syringe should be selected with a sharp and smooth-pointed needle; the syringe should be charged with pure carbolic acid, and all air bubbles excluded. The patient should stand up so as to bring the veins into strong relief, and whilst in that position an Esmarch's tube or bandage should be applied tightly round the thigh. The patient should then lie down, and the needle should be inserted into the vein, and half a minim of carbolic acid injected. This should be repeated in as many places as might seem requisite; ten or twelve might be safely made in a large varix. The tourniquet should be left on for ten minutes after the last injection; he usually allowed fifteen minutes. The only dressing required was a little pad of some antiseptic wool, such as the sal alembroth, or salicylated wool applied quite lightly, and kept in place by a soft, light bandage. It was most easy to miss the vein, especially if the needle had a rough point. When the vein was missed, no blood followed the withdrawal of the needle, and a small suppuration in the connective tissue usually followed. On the other hand, when the vein was pierced, a spot of dark blood escaped when the needle was withdrawn. Coagulation seemed at once to commence; the vein could be seen becoming fuller, and soon it felt firmer to the touch, so that a clot could be distinctly felt before the operation was concluded. The patient should be kept in bed for a week or ten days. In choosing cases for this method of cure, he thought that a vein which had very decided clusters of varices was better suited than where the varicose vein consisted merely of a straight, long, dilated vessel. In such a condition the needle operation or excision was preferable. He had met with no accident or untoward circumstance in performing this operation; the results had in all cases been satisfactory. The procedure was comparatively simple, and no anæsthetic was required.—*Br. Med. Jour.*, Oct. 5, 1889.

Dorland (W. A. N.) on Facial Erysipelas Complicating a Varicose Ulcer of the Foot.—A stout woman, fifty-two years of age, was suffering from a large ulcer, involving the whole dorsum of the right foot, and extending to about two inches above the ankle joint. The woman stated that it had commenced with the bursting of a dilated vein at a spot just below the external malleolus, from which initial point it had rapidly spread, until it

had reached the dimensions it then had. Upon examination, numerous varicose veins of considerable size were found extending up the limb to the knee. The ulcer was healthy in appearance, and presented no edge of induration. Attempts at strapping proved painful; a simple dressing of iodoform was made, followed by the tight application of a roller bandage. Under this treatment granulation progressed rapidly, until November 4th, when he was hastily summoned, and found the patient laboring under considerable fever, which was subsequent to a chill. The whole surface of the ulcer, which till then had been discharging freely, was dry, glazed, hot, and painful, and strongly erysipelatous in appearance, while under the left eye was a suspicious looking, dark-red spot. Upon investigation it was found that the patient had left her room on the previous day, and had remained down stairs for three hours in attendance upon her household duties. She stated that one paternal aunt had suffered with erysipelas, that her sister had died of the meningeal form, that another sister had had a severe attack of the disease, from which she had recovered, while she herself had passed through two previous attacks—the first appearing in her leg, and the last a slight attack in her face.

Incision of the erysipelatous patch in her limb not being permitted, much relief was afforded by the application of cloths wrung out of hot water. The spot under the eye rapidly assumed an erysipelatous character, and invaded the surrounding surface, closing both eyes, and involving most of the forehead—stopping, however, at the border of the hair. She was placed upon full doses of quinine, together with thirty drops of the tincture of the chloride of iron, every two hours, and upon tablespoonful doses of a preparation of beef, wine, and iron after meals. In four days she was practically well.—*Times and Register*, Dec. 14, 1889.

Extirpation of a Seminal Vesicle.—Dr. Ullmann has recently extirpated the seminal vesicle and the vas deferens on the right side in a patient, aged nineteen, who some weeks ago had been castrated on account of tuberculosis of the right testicle. The operation was performed to prevent the infection of the genital organs on the left side, which seemed to be healthy. The incision was made through the perineum, and then the infiltrated right vesicle and the right vas deferens were removed, while the corresponding organs on the left side remained intact. After a few weeks the wound was healing perfectly, and the patient is now in good health.—*Lancet*, Nov. 30, 1889.

A New Operation for Incontinence of Urine.—Dr. R. Gersuny, of Vienna, who some time ago transplanted a rabbit's nerve into Professor von Fleischl's arm, has recently devised a new operation for incontinence of urine. In a case of epispadias in a girl, the urethra admitted the little finger, and had the form of a funnel, 1 centimetre long; the clitoris was cleft; there was complete incontinence of the urine. At the age of 14 years the mucous membrane corresponding to the cleft was excised from the anterior commissure of the labia up to the neck of the bladder, and the edges of the cleft were sutured. The girl was then operated on by Professor Pawlik, according to his own method, but the patient could hold her water only for an hour when sitting; on walking or standing she could not do so at all. Five years later Dr. Gersuny operated on the patient, who was then 19 years old, by laying bare the urethra as far as the arcus pudendi, twisting the external orifice of the urethra to the extent of a semicircle (180°), and suturing it in this position. The success was incomplete, and this was also the case after a second operation, in which the urethra was further twisted to the extent of 90°. Four weeks later a further twisting, to the extent of 180°, was effected. This proved completely successful. The external orifice of the urethra was turned round to the extent of one circle and a quarter (450°), and the urethra was twisted in its longitudinal axis in the form of a screw. After the last operation there was retention of urine (ischuria) for three days, so that the patient had to be catheterized. From that time she could micturate spontaneously, and the urine never passed involuntarily. The capacity of the bladder was at first from 100 to 200 cubic centimetres. Evacuation took place under strong pressure, and lasted for ten minutes. This condition improved rapidly, and after five months the patient could hold her water for five hours in any position; then she was attacked with strong tenesmus, and evacuated, without effort, half a litre of urine; the act, however, still required about four minutes. The progressive improvement was the result of the gradual dilatation of the bladder and the strengthening of the detrusor

urinæ. The operation of Dr. Gersuny is indicated in those cases in which the sphincter of the bladder is quite powerless and the detrusor intact.—*Br. Med. Jour.*, Nov. 9, 1889.

Salpingostomy.—Doctor Skutsch has practised a new gynæcological operation. Since the introduction and general diffusion of salpingotomy as an operation recognized and justifiable, at least, in prudently selected cases, many have suggested that at least an attempt might be made to save the diseased tube after opening its occluded cavity and freeing it from adhesions. Practice has shown that the danger of meddling with the affected parts in such a manner, and then closing the abdominal wound, is fraught with risk. Dr. Skutsch proceeds in a systematic manner to conservative ends, or, at least, did so in one case. The patient was sterile and aged 28. She suffered from pelvic pains, and it is stated Dr. Skutsch diagnosed obstruction and dilatation of both tubes. This diagnosis was confirmed by abdominal section. A Pravaz syringe was employed in order to puncture each tube and ascertain its contents. As clear yellow serum was drawn away, the operator determined to save the tubes. An oval piece, about one square centimetre in size, was cut out of the outer end of each tube, and the mucous and serous coats united by fine silk sutures around the border of the hole thus formed. A sound was then easily passed from the tube into the uterine cavity on both sides. The patient made a good recovery, and was relieved of her pains, but a long after-history is not given. Dr. Skutsch calls this proceeding "salpingostomy." In some cases of pyosalpinx it would be advisable, he thinks, to sew the ends of the tubes to the abdominal wound, to open them and allow them to discharge pus externally. When the discharge ceased to be purulent the tubes might be freed from their artificial attachments and replaced in the pelvis.—*British Med. Jour.*, Nov. 30, 1889.

MISCELLANY.

Statistics of Leprosy in the United States.—In view of the general impression that leprosy is spreading in this country, it is desirable, in the interest of the public health, to obtain accurate information on this point. The undersigned is engaged in collecting statistics of all cases of leprosy in the United States, and he would ask members of the profession to aid in this work by sending a report of any case or cases under their observation, or coming within their knowledge.

Please give location, age, sex, and nationality of the patient, and the form of the disease—tubercular or anæsthetic; also any facts bearing upon the question of contagion and heredity.

Address Dr. Prince A. Morrow, *Journal of Cutaneous and Genito-Urinary Diseases*, 66 West 40th Street, New York.

Alexander (H. C. B.) on Iodine Locally in Erysipelas.—The local use of iodine in erysipelas is not by any means a novel procedure. It seems, however, to have fallen into disuse, chiefly because, in all probability under modern antisepticism the disease itself has greatly decreased.

Among the insane, owing to filthy habits and overcrowding, erysipelas is very prevalent. In the Cook County Insane Hospital in 1885 the disease was easily checked by the following procedure. The erysipelatous surface was painted with tincture of iodine, three coats being put thereon. For an inch around the affected space the skin was painted deeply with iodine. Internally tincture of iron perchloride was given for renal and cardiac reasons.

Under this treatment the most furibund erysipelas—and erysipelas is peculiarly furibund among the insane—yielded rapidly. A patient whose face would be found so enormously swollen as to make her unrecognizable as a human being, would, in three days become perfectly well. The skin of the face would scale off without disfigurement, and for sometime thereafter its sluggish circulation would be improved. —*Med. Standard*, Dec., 1889.

BOOK NOTICE.

The Physician's Visiting List (Lindsay & Blakiston's) **for 1890.** Thirty-ninth year of its publication. Phila.: P. Blakiston, Son, & Co.

The present book is for 25 patients per week. Price $1.00.

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